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Toward a medical ethics that cares

A theoretical and normative study of ill-being and care in medicine

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“Denne boken er som nevnt ikke blitt slik den var tenkt. Likevel er den også blitt slik den var tenkt” (Kari Martinsen i *Fra Marx til Løgstrup*, 2003, s.13).

Dedicated to my family.

Abstract

This thesis stems from a wish to better understand human illness and patient care and the connection between them in medicine. A main assumption in the thesis is that the understanding of both patient and physician in medicine and medical ethics is too narrow to accomplish the goal of *helping and taking care of the sick*. In the thesis I carry out a theoretical study with the aim of investigating some of the preconditions for reaching this goal of caring for the sick in medicine, focusing on *ill-being* and *care*.

The thesis consists of two parts, with the first part of the study focusing on the human being in need—the *homo patiens*—and the state of being ill, and the second part of the study focusing on the medical helper—the *homo compatiens*—highlighting a perspective that is seldom focused on in medicine and medical ethics: namely, the physician as carer.

First, I focus my attention on the illness dimension of human ailment, aiming to advance an understanding of illness as “a way of being human.” As a conceptual point of departure, I suggest the notion of “pathic existence” as developed by the German physician and philosopher Viktor von Weizsäcker (1886–1957). Through an analysis of his conceptualization of the pathic and of pathic categories, I demonstrate how this auxiliary typology may be of help in revealing different modes of ill-being.

Second, to provide a richer account of what it means to conceive of the physician as helper and caregiver, I analyze care and the relevance of care ethics in medicine, arguing that care should be given a more central role in medical ethics than it has received to date. Care ethics challenges medicine’s “eye,” and being able to see patients with what Kari Martinsen calls a “perceiving eye” can help us take better care of the patient as well as improving our clinical “nose” and our diagnoses. I refer to the latter aspect as the epistemic potential of care. Further, I point to how an assumption of the self as being “autonomous and alone” combined with the underlying attitude of medicine to human ailment as something to get rid—of “weg damit”—may contribute to poor conditions for care in medicine, leading to situations where patients are harmed by the absence of care.

In order to facilitate care in medicine and medical ethics, we need to realize the relational reality of the moral self and acknowledge the pathic mode of human existence. When a human ailment is considered not just as something to get rid of but also as basic and

constitutive for our existence, for our way of being human, both the illness dimension of an ailment as well as caring approaches to it may be given more room to develop in medicine.

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Prologue

As a graduate student of medicine I met a patient from Bosnia who was terminally ill with cancer with multiple metastases. While the civil war was raging at its worst in his homeland, he was waiting to die here in a foreign country. At his bedside our teacher taught us to interpret the CT scan of the patient's abdomen, which showed a liver full of metastases. He taught us how to use percussion to demonstrate the presence of ascites, and to recognize the liver stigmata he exhibited because of a liver destroyed by cancer cells. But he did not teach us to interpret the loneliness in the patient's eyes. We did not even look for what his eyes may have held. As the other students hurried down the corridor trying to keep pace with the teacher, I looked into the patient's room one more time, and saw him sitting by the window looking out. He seemed extremely lonely, and I felt ashamed of our behavior. I never forgot that patient, and I asked myself when I was standing in the corridor: What do we know about what it is to be an ill human being? What knowledge do we have of the ill person himself or herself? What does suffering from a serious disease or a disease that can be cured entail? We learn the details about the purely objective aspects of human disease: about pathogenesis, diagnosis, prognosis, and treatment. We learn to interpret CT scans and how to percuss the abdomen, but what do we learn about living with an illness?

List of papers

I Martinsen, E. H. (2011). Care for nurses only? Medicine and the perceiving eye. *Health Care Analysis*, 19, 15–27.

II Martinsen, E. H. (2011). Harm in the absence of care: Towards a medical ethics that cares. *Nursing Ethics*, 18(2), pp. 174–183.

III Martinsen, E. H., and Solbakk, J. H. (2012). Illness as a condition of our existence in the world: On illness and pathic existence,” *Medical Humanities*, 38, 44–49.

1. Introduction

My encounter with the Bosnian patient as a medical student represents in many ways the starting point for this thesis. Meeting patients for the first time I felt the medical perspective we were introduced to was too limited, in relation to patients, but also in relation to the task of being a physician. Even though the patients we examined often suffered from life-threatening conditions, our clinical bedside education focused mainly on the patients' physical diseases. Seldom, or never, did we discuss the more existential aspects of illness: patients' anxiety, loneliness, and sufferings, and their fear of dying and death. Nor did we ever discuss or have occasion to reflect upon our own reactions to the patient's situation.

Based on my experiences I started to explore this problem further, pointing to the importance of being touched emotionally in meeting with patients' suffering as a medical student (Martinsen, E. H., 2000), as well as searching for a more "holistic" understanding of both patient and professional (Martinsen, E. H., 2004). I yearned for such a more "holistic" view of patients. And I asked for a different view of myself and my fellow colleagues, as physicians-to-be: Was it part of our job to focus also on the patient's loneliness and fear of death? And what about our own reactions to some of the situations we encountered? For me there was a discrepancy between our dealing with the Bosnian patient's physical signs of malignant disease and our appreciation of his existential situation, that of a refugee in a foreign country about to die. I felt we did not treat him well enough, even though he got the best quality of medical care. We were not interested in his situation beyond his purely medical condition. We never looked for what his eyes may have held. And, even more important, this was not considered by our teachers something we as medical students should learn and think about.

This medical encounter and my attempt to give emotional and normative expression to it (Martinsen, E. H., 2000, 2004) forms the starting point of this doctoral thesis. This "basic experience" triggered a reflection from which my two basic problems originated: 1) What was it like to be the Bosnian patient? Or, more generally: What is it like to be a patient, to be ill? And 2) What was it like to be me in the actual situation, as a physician-to-be, sandwiched between colleagues and a teacher, hurrying down the corridor—and my own feelings and thoughts regarding the patient? Or more generally: How do we understand and deal with the inherent tension in physicians' work between the objective and intellectual

approach to the sick human being, and the personal and emotional responses to this human being's suffering?

This dissertation stems, then, from a wish to better understand human illness and patient care, and the connection between them in medicine. A main assumption of the project is that the understanding of both patient and physician in modern medicine is too narrowly defined to accomplish its goal of helping and taking care of the sick (Cassell, 1976). In this project I carry out a theoretical study to investigate some of the preconditions for reaching the goal of caring for the sick in medicine. The principal objective of the dissertation has been *to develop theoretical insight in medicine in order to contribute to a better normative understanding of what care for the ill person entails*.

Despite a growing health bureaucracy and advances in medical technology, the basic unit in medical work is still the relationship between the doctor and the patient: two individuals who meet, one applying for help and the other one there to offer help. We can formulate this as a basic phenomenon ("Urphänomen") or a basic structure for medical activity: "The ill human being, who is in need [Not], who needs help, and, who therefore contacts the physician" (von Weizsäcker, 1987a, p. 13).¹ This basic phenomenon is constituted by two dimensions of need and of help: the human being in need, the *homo patiens*, and the human being providing help, the *homo compatiens* (Schipperges, 1984). My focus of interest is on this dyad of patient and physician, and in this thesis I work with questions regarding the human being in need, *the homo patiens*, as well as with the human being as providing help, *the homo compatiens*. These two dimensions of need and help correspond with my two initial questions of what it involves to be ill—to be a person in need—and what it involves to be a physician—to be the person who provides help.^{2, 3}

Hence, instead of analyzing the situation with the Bosnian patient in light of the usual medical ethical concepts like "lack of dignity," "lack of integrity," "lack of respect for

¹ " ... der kranke Mensch, der eine Not hat, der Hilfe bedarf und dafür den Arzt ruft" (von Weizsäcker, 1987a, p. 13).

² I translate the German expression "kranke Mensch" as "ill human being." In the text, however, I use the expressions "ill human being" and "ill person" interchangeably.

³ The works of Viktor von Weizsäcker are not translated into English. For this reason, the translations from German into English in this thesis are my own, in cooperation with my supervisor Jan Helge Solbakk, except for one instance when I use a translation provided by Monica Greco (Greco, 2009, pp. 36-37). When I quote directly from a text I offer the original text in its original language in parentheses or a footnote.

persons,” and “lack of empathy,” I try to fill what I perceive as an epistemological gap in medical education: a failure in relation to the *homo patiens*, as well as in relation to the medical profession and the medical helper, the *homo compatiens*. The dissertation thus belongs to the subject area of philosophy of medicine and medical ethics. The starting point of the thesis is more or less situated within the philosophy of medicine *proper*, but it evolves subsequently into medical ethics, discussing among other things the concept of care and the tradition of an ethics of care in relation to medicine.

1.1 Exploring the basic phenomenon

1.1.1 The human being in need: The *homo patiens*

The first part of my study focuses on *homo patiens*, the human being who is ill. Medicine possesses a comprehensive conceptual and theoretical framework for coping with the organic aspects of human disease. However, caring for the ill is more than curing the disease. This suggests that medicine is in need of theoretical perspectives that exceed the traditional areas of pathogenesis, diagnosis, and treatment. In this study I search for a philosophical approach to illness, asking what it is like to suffer from imbalanced neurotransmitters, infected sinuses, mutated gene sequences, or structural pathology. What is it like to experience illness?

This question was raised by the German physician and philosopher Viktor von Weizsäcker (1886–1957) at the beginning of the last century. In his essay “Der Arzt und der Kranke” (the physician and the ill), he points to the fact that “medicine has no theory of its own about the ill human being. It teaches us about appearances of illness, about differentiation of causes, about outcomes [of disease], about different types of medical treatment, but it does not teach us about the ill human being” (von Weizsäcker, 1987a, p.12).⁴ Von Weizsäcker is a central theoretician in the tradition of anthropological medicine within the philosophy of medicine. This tradition was popular, particularly in Germany and the Netherlands, from approximately 1920 until 1960, but has fallen out of favor over the last four decades. The

⁴ “Es ist eine erstaunliche, aber nicht zu leugnende Tatsache, daß die gegenwärtige Medizin eine eigene Lehre vom kranken Menschen nicht besitzt. Sie lehrt Erscheinungen des Krankseins, Unterscheidung von Ursachen, Folgen, Heilmitteln der Krankheiten, aber sie lehrt nicht den kranken Menschen” (von Weizsäcker, 1987a, p. 12).

main interest of this tradition was to redefine and reinterpret medicine as a science of the human person (ten Have, 1995).

In my thesis I offer an analysis of some of the works of von Weizsäcker with the aim of identifying in them a perspective on the ill human being. I focus my attention on the illness dimension of human ailment. In the literature of philosophy of medicine there is an established conceptual distinction between “disease,” “illness,” and “sickness,” referring to the medical, personal, and social aspects of human ailment respectively (Hofmann, 2002a). The concept of “disease” denotes the scientifically defined aspect of being sick, whereas “illness” denotes its experiential, subjective counterpart. “Disease processes are ‘located’ in tissues and organs. Illness strikes towards human beings—towards their aspirations, their plans and hopes and desires. The ways individuals react when ill are almost endlessly varied and deeply affect how they want to, may, and ought to be treated” (Ahlzèn, 2011, p. 325). Illness can be described as a condition, something that happens to a person—but also as mode of being, that is, as a way of relating to, of being in, the world (Elstad, 1987). In this thesis I understand illness as being, as a way of relating to the world, and I take the notion of pathic existence, as elaborated by Viktor von Weizsäcker, as my point of departure. Through an analysis of von Weizsäcker’s conceptualization of the pathic and of pathic categories, I point to how his understanding of pathic existence may be relevant to illness and the illness experience. I argue that the pathic categories of “wollen,” “können,” “müssen,” “dürfen,” and “sollen” may reflect different modes of *ill-being*, of “Kranksein.” By so doing, I interpret Viktor von Weizsäcker within a phenomenological frame of reference. Within medical philosophy and nursing science, phenomenological perspectives on the experience of illness are common, and much research has been done using phenomenology as a theoretical ground (Kaufman, 1988; Toombs, 2001; Nortvedt, 1996, 2008a; Svenaeus, 2000, 2009, 2011; Carel, 2008, 2011; Ratcliffe, 2008; Elstad & Torjuul, 2009; Zeiler, 2010). In light of this, I argue that it might be interesting and fruitful to emphasize a less well known position within medical philosophy that deals with many of the same problems.

Though von Weizsäcker is not widely considered to be part of the phenomenological movement, his works on the pathic and pathic existence may be usefully so interpreted. In calling for a perspective on the ill person that also involves the person’s ill-being (“Kranksein”), as well as by elaborating on pathic categories or modes of being, von

Weizsacker presents a description of lived experience that is very much in the spirit of the phenomenological approach to philosophy.

1.1.2 The human being as helper: The homo compatiens

The second part of the study focuses on the medical helper, *homo compatiens*, invoking a theoretical perspective seldom focused on in medicine and medical ethics: the physician as carer. Whereas physicians' behaviors are often analyzed in terms of their communication skills or their empathic capacities, care or the act of caring is rarely discussed within medicine.

Although seldom reflected upon in medicine, care is a thoroughly elaborated concept in nursing science. Similarly, an ethics of care has exerted an influence in the areas of health care ethics related to nursing, but has not had the same influence on the theoretical frameworks on which physicians mainly rely for their ethical reflection. This is the case even though the concept of care has a long historical tradition within medicine (Reich, 1995a). In medicine, care is traditionally seen as a cluster of altruistic virtues (Reich, 1995b). Sympathy and compassion have had a special influence within the profession by informing the sensitivities of medical practitioners as well as by representing ethical ideals formulated in medical codes and oaths. "Cure sometimes, treat often, comfort always" is a well-known aphorism in medicine, ascribed to Hippocrates. The sentence is often regarded as a definition of medical activity, and conceives of comfort as always obligatory on the part of the physician. We find similar sentiments in the first article of the ethical guidelines of Norwegian physicians, which states that the doctor shall cure, treat, and comfort. The second article admonishes, among other things, that "The doctor must attend to the individual patient's interests and integrity. The patient shall be treated with compassion, care and respect" (*Code of Ethics for Physicians*, 2002). There is also a legal requirement to provide "diligent care": the Norwegian Health Personnel Act in its fourth paragraph states that: "Health personnel shall conduct their work in accordance with the requirements of professional responsibility and diligent care that can be expected based on their qualifications, the nature of their work and the situation in general" (*The Health Personnel Act*, § 4).⁵ Thus we see that in addition to being expected to provide medically sound help, physicians, as health care personnel, are also required to provide "diligent care." The

⁵ The Norwegian expression used in the law text is "omsorgsfull hjelp" (*The Health Personnel Act*, §4).

Norwegian Board of Supervision issues written warnings to health care personnel who fail to provide it. As I see it, this legal requirement to provide caring help points to a demand for greater consciousness with regard to care in medicine with respect to both medical practice and medical ethics. This thesis is a contribution to this end.

Working within the fields of medical philosophy and medical ethics, I have often been puzzled by the theoretical discrepancy between nursing and medicine in this regard. Whereas care features extensively in the literature of nursing ethics, it is still situated at the margins of much of the ethical thinking in medicine. Why so? Do not doctors and nurses work in the same field, and with the same patients? Some recent work (Carse, 1991; Branch, 2000; Branch et al., 2001; Cluff & Binstock, 2001; Cates & Lauritzen, 2001; Weiner & Auster, 2007; McCabe, 2008; Kleinman & Van der Geest, 2009; Jacobson et al., 2009; Kohlen, 2009; Marcum, 2011; Paulsen, 2011; Sommer et al., 2011; Hamington, 2012; Langley & Egan, 2012) seems to be more open to the feasibility of an ethics of care in medicine and medical ethics, and this study aims to facilitate this transition. Thus, the second part of my project focuses on the concept of care in medicine, and attempts to illuminate possible practical and ethical implications of emphasizing it. How may these perspectives help me in resolving, or at least better understanding, what was at stake in my encounter with the Bosnian patient?

The Norwegian nursing scientist and philosopher Kari Martinsen's scholarly works on care, nursing, and medicine represent the starting point for this part of my investigation (Martinsen, 1991, 2000, 2003a, 2003b, 2003c, 2006). I introduce her theoretical framework on care, arguing, with her, that medicine needs to encourage practitioners to develop what she calls a "perceiving eye." The fostering of such a gaze may facilitate care in each medical encounter, I argue, as well as refining clinical proficiency. Kari Martinsen's work has influenced the current understanding of care in nursing in Scandinavian countries, and she belongs to a different theoretical tradition than the Anglo-American tradition of an ethics of care. Investigating Martinsen in the context of medicine will be interesting; it may help us bridge the gap between related research traditions in medicine and nursing.

I continue my investigation of care in medicine by turning to the Anglo-American ethic of care as developed by scholars like Carol Gilligan (1982), Virginia Held (2006), Joan Tronto (1993), Eva Feder Kittay (1999), and Tove Pettersen (2008). The starting point of this ethical tradition may be traced to the work *In a Different Voice* by Carol Gilligan (1982). In

this book, Gilligan studies the moral development of school children. Interviewing schoolgirls, she identifies a specific moral voice, one where *caring for others in interpersonal relationships* is the main moral concern, a concern that according to Gilligan may be captured in the moral demand to “not turn away from someone in need.” Gilligan describes a *resistance* among the girls she interviews toward the dominant culture, in which autonomy and rationality are considered markers of moral maturity. Through her work, Gilligan recognizes an ethical voice that has been “held in silence”: “It was like shifting the frequency and suddenly hearing a station that had been jammed” (2011, pp. 5–6).

May my own reaction in the case of the Bosnian patient be ascribed to a *resistance* like that Gilligan points to? In meeting the patient with my fellow students and teacher, I too experienced a reaction against the way we acted in that situation, leaving the patient without considering anything but his physical deviations. So, standing in the corridor, hesitating, torn between having to catch up with the “white coats” at the end of the corridor and wanting to approach “the loneliness in the patient’s eyes,” I started looking for a “different voice” in medicine in the context of the medical encounter, a quest that has led me into the anthropological tradition of medicine, nursing perspectives, and feminist ethics of care.

1.2 Objectives of the study

Principal objective

To develop theoretical insight in medicine in order to contribute to a better normative understanding of what care for the ill person entails.

Intermediate objectives

1. With the aid of a theoretical study, to illuminate what is involved in being perceived as, and existing in the world as, an ill person, thus contributing to a theoretical perspective on ill-being; in von Weizsäcker’s words, developing and making visible a “pathosophy” in medicine.
2. To explore how the conceptual vocabulary of an ethics of care might contribute to illuminating ill-being and the ill person–medical helper relation.

3. To make visible some consequences of introducing the concepts and perspectives developed in this thesis for today's medical practice.

I approach the principal objective of the thesis from different angles. First, I try to illuminate theoretically important aspects of the experience of being ill, thus exploring the *homo patiens*. Through a focused reading of von Weizsäcker, I try to grasp important elements of ill-being. Further, I argue that von Weizsäcker's medical anthropology not only embeds elements necessary for an understanding of the pathic subject in medicine, the patient, but that his approach has relevance beyond this context, as a general perspective on man. Second, I turn to *homo compatiens*, analyzing conditions for physicians that make them able to "see and express the [patient's] appeal for help, in order to strengthen the [patient's] life courage in the suffering" (Martinsen 1993, p. 9),⁶ arguing that the development of a sensuous and perceiving gaze is important in order to facilitate care and refine clinical proficiency. Third, I "join the resistance" (Gilligan, 2011) of care ethics, arguing that the dominant ideals of detachment and non-interference in medicine need to be challenged, and that medicine and medical ethics may profit from implementing the "relational ontology" of an ethics of care, working for an understanding of physician and patient as related selves. The fourth and last part of the thesis will consist of an overarching discussion of the different theoretical perspectives addressed in the previous chapters. Ethical analysis runs as a thread through the project, illuminating the ethical implications of von Weizsäcker's medical anthropology, and justifying the introduction of a more content-rich care perspective in medicine.

There is thus an internal connection among the three theoretical perspectives of the thesis, which originates in the phenomenon of ill-being and the "plea for help" formulated by Viktor von Weizsäcker. With these basic phenomena as his points of departure, von Weizsäcker highlights the need ("Not") of the patient as the main task for medicine and the medical helper to address (von Weizsäcker, 1987a). Similarly, highlighting the importance of health care practitioners to "be able to see and express the [patient's] appeal for help," Kari Martinsen points to the patient's need, expressed as a cry or an appeal for help (Martinsen, 1993, p. 9). Through her elaboration of what she calls a perceiving gaze and a recording gaze, Martinsen points to the importance of the medical helper *noticing* the need

⁶ "Vi må både kunne se og kunne uttrykke appellen om hjelp for å kunne styrke livsmotet i lidelsen" (Martinsen, 1993, p. 9).

to care. Martinsen's main focus is a relational one, highlighting the relation between the human being in need and the human being as helper. We also find this relational focus in the Anglo-American tradition of an ethics of care, representing the third theoretical perspective that I rely on in this thesis. In our third theoretical perspective, an ethics of care highlights the ethical importance of relationships, and through this provides us with some interesting concepts to deal with the ethical challenges inherent in the basic phenomenon as elaborated by von Weizsäcker. Hence, both the understanding of the moral self as related and the ethical ideal of not turning away from someone in need may contribute to an improved understanding of the *homo patiens*, the *homo compatiens*, and the relation between them. By revisiting the model of the moral agent in medicine and medical ethics, relying on the relational ontology of an ethics of care, I further a central ambition of the tradition of medical anthropology, which is to clarify and interpret "the images of persons that underlie ethical perplexities" (ten Have, 1995, p. 3). The trajectory of this thesis from an anthropologically oriented perspective into an ethical discussion of the relevance of an ethics of care in relation to medicine reflects the connection between the anthropological tradition of medicine and the subsequent development of the academic field of medical ethics.⁷

The thesis consists of five chapters, including the introduction and the conclusion. In Chapter 2 I present my three theoretical perspectives through a more thoroughgoing account than is provided in the three earlier papers in which I have presented portions of this work. In Chapter 3 I provide a synopsis and a reassembling of the three papers, as well as an account of the new insights gained from this work. The three papers are:

- Paper 1: "Care for nurses only? Medicine and the perceiving eye" (Martinsen, E. H., 2011a).
- Paper 2: "Harm in the absence of care: Towards a medical ethics that cares" (Martinsen, E. H., 2011b).

⁷ Henk ten Have highlights this connection in his article "The anthropological tradition in the philosophy of medicine" (ten Have, 1995) pointing to how anthropological medicine has paved the way for the subsequent interest in ethical issues in health care by concentrating on the subjectivity of the patient: "The tradition of anthropological medicine made visible and laid open, so to speak, the moral dimension of medicine. It did so by criticizing the presuppositions of the dominant conception of medicine as natural science, and by incorporating medical science's analytical methods and mechanistic image of a human being in a broader framework of an authentic science of humans" (ten Have, 1995, p. 11).

- Paper 3: “Illness as a condition of our existence in the world: On illness and pathic existence” (Martinsen, E. H. & Solbakk , 2012).

In the fourth chapter I enlarge on central themes from the previous analyses. I offer a reflection on what it may imply for medicine to understand illness as a “way of being human,” contrasting it with the attitude of “weg damit” (away with it) characteristic of today’s medicine. In addition, I enlarge upon and discuss the different ways of seeing in medicine, as well as revisiting the model of the moral agent inherent in medicine and medical ethics. I investigate the prevailing understanding of care in medicine, trying to address more thoroughly the question of why medicine seems to remain ambivalent about care. I try to respond to some of the critiques of care in medicine, and reflect on some of the didactical challenges related to the task of facilitating care in medicine. Finally, I indicate some areas for further research.

1.3 Methodological considerations

The research process led me from the anthropological perspective of von Weizsäcker to contemporary discussions of an ethics of care. From an interest in the person who is ill, I became curious about the *homo compatiens*, the medical helper. Initially this project was entitled “From divided objects to whole subjects: Holistic philosophy in medicine.” One of my original goals was “to contribute to a clearer and a more productive understanding of the concept of holism in medicine.” However, while searching for a feasible holistic approach in medicine, my focus changed, and I became increasingly interested, instead, in the concept of care. This process of change was catalyzed by my reading of nursing literature on holistic care.⁸ In addition to studying international literature on holism in nursing, I also began to read Norwegian literature within this field (Hummelvoll, 2004; Nortvedt & Grimen, 2004). To orient me in this theoretical landscape, which was unfamiliar to me as a physician, one specific name stood out and was repeatedly referred to in the different texts: the name of Kari Martinsen. I became curious about her work and her philosophy of care, asking myself why such an influential Norwegian theoretician on care in nursing was

⁸ See for instance Myra E. Levine (1971), Geertje Boschma (1994), and Simon Woods (1998).

completely unknown to me as a physician. In reading her works I subsequently questioned whether my search for a more “holistic approach” in medicine was possibly a search for a “caring approach” toward patients. I found the care philosophy of Martinsen fruitful for a better understanding of patient, physician, and the relationship between them. This led me to further explore the field of care ethics, expanding my reading from the Nordic tradition of Kari Martinsen, Per Nortvedt, and others to the Anglo-American tradition of an ethics of care rooted in feminist ethics and feminist philosophy.

This project entails in-depth studies of primary and secondary literature within all three areas. The method employed is philosophical analysis. Working with the texts, I dissect, discuss, and look for concepts and theoretical connections. The adaptation of the literature will follow the common principles of philosophical analysis: clarification of concepts, examination of definitions, and comparison of different positions. Since the questions considered are conceptual rather than empirical, requiring a discursive approach, I utilize some case stories as well to reflect on these issues. I make use of different kinds of stories from different sources, including a real case from my own experience as a physician as well as cases from medical journals, from magazines, and from books, both texts and novels. In Chapter 4 I also make use of some scenes from the movie *Wit*, which is based on a play by Margaret Edson.⁹ These different cases do not represent an attempt to “mirror” reality, as they include fictional cases as well as cases from real life. Their function is rather to act as a substrate for the theoretical discussion, illuminating crucial aspects of the analysis, as well as clarifying important points.

The analysis and discussion of the literature will be framed within a hermeneutical context. Here I am inspired by Kari Martinsen, who describes this hermeneutical process as one of “thinking with” the actual theoreticians in the field we aim to examine (Martinsen, 2003b, 2003c). My interpretations or ways of “thinking with” are conditioned by my own horizons, of course. This means that others might interpret the texts differently. This constitutes the *pre-understanding* with which I enter into the project. The pre-understanding is the “rucksack that we carry with us into the research project before the project starts. The content of this rucksack influences all the ways we gather and read our data. ... This baggage consists of experiences, hypotheses, professional perspectives, and of the theoretical frame of reference that we have by the opening of the project” (Malterud, 2003,

⁹ *Wit* is a 2001 American television movie directed by Mike Nichols based on the Margaret Edson play.

pp. 46–47).¹⁰ As a trained physician, I might read the texts differently than if I were a trained philosopher or a nurse. Hence, the starting point for this project is my own experience as a medical student and a physician, calling for a more “holistic” patient perspective and a “caring approach” in our medical training. This pre-understanding constitutes an important motivation for carrying out this project. However, it is important to be aware of my pro-caring attitude, lest it predetermine the results of my investigation. So I must be careful to revisit anti-caring arguments thoroughly in the analysis, while at the same time being open to modifying, or even rejecting, some of my earlier pro-caring assumptions in case the arguments should not hold. In Chapter 2, where I present the perspectives of Viktor von Weizsäcker, Kari Martinsen, and the tradition of an ethics of care, I end each section with a scrutiny of possible criticisms. Likewise, I try to critically evaluate my idea of introducing care in medicine in the final discussion in Chapter 4.

1.4 Indicating some results

This thesis will contribute to a further development of the field of philosophy of medicine and medical ethics, bringing to light theoretical traditions that are seldom touched upon in these contexts. It points to ethical and epistemological challenges rarely discussed in today’s medicine and medical ethics, and illuminates how the anthropological activity of clarifying and interpreting “the images of persons that underlie ethical perplexities” (ten Have, 1995) may be necessary for the proper resolution of moral problems in medical ethics. It questions the underlying idea that the moral self in medical ethics is a separate and emotionally detached self that always strives for the healthy, the finished, and the complete. The thesis points to how an assumption of the self as “autonomous and alone,” combined with the underlying attitude of medicine that human ailments are something to be eliminated (of “weg damit”), may contribute to poor conditions for care in medicine. It argues that medicine, in order to facilitate care, needs to realize the relational reality of the moral self, as well as to acknowledge the pathic mode of human existence. That is, when human ailment is considered not only as something to get rid of but as something basic and

¹⁰ “Forforståelsen er den ryggsekk vi bringer med oss inn i forskningsprosjektet, før prosjektet starter. Innholdet i denne ryggsekken påvirker hele veien måten vi samler og leser våre data. ... Denne bagasjen består av erfaringer, hypoteser, faglig perspektiv, og av den teoretiske referanseramme som vi har ved prosjektets innledning” (Malterud, 2003, pp. 46-47).

constitutive of our existence—for our way of being human—the illness dimension of ailment, as well as caring approaches to it, may be given more room to develop in medicine.

By bringing care discourse from nursing philosophy and feminist ethics into the “father-house” of medicine, I also believe that the thesis will help to promote more interdisciplinarity, not only in the theoretical disciplines of medical ethics and philosophy of medicine, but also in the clinical field, where physicians and nurses work side by side with the same patients. This work thus hopes to initiate the development of common inquiry in the area of what is often considered a tension between medicine on the one hand and nursing on the other: between curing and caring. Perpetuating a dichotomy between care and cure does a disservice to both. By discussing care and an ethics of care in relation to medicine and medical ethics, the thesis offers a way of combining insights about the basic phenomena of ill-being and need from medical anthropology with the perspectives of care offered by nursing and feminist ethics so as to contribute to the building of a more sustainable theoretical and normative framework for handling ill-being and pleas for help in medicine.

2. Theoretical background: From medical anthropology to an ethics of care

2.1 Viktor von Weizsäcker and the pathic modes of illness

2.1.1 *The tradition*

Viktor von Weizsäcker is one of the main contributors to the anthropological tradition in philosophy of medicine. The tradition is not well known outside Germany and the Netherlands, and most of the scholarly works pertaining to this tradition, including the works of von Weizsäcker himself, have not been translated into English. In Germany this movement is labeled “Medizinische Anthropologie” or “Anthropologische Medizin” (von Weizsäcker, 1987b; Seidler, 1984; Christian, 1989). The Dutch term is “medische anthropologie.”

This tradition, the German-Continental tradition of medical anthropology, should not be confused with the Anglo-American tradition of medical anthropology, which is a subfield of anthropology that draws upon social, cultural, biological, and linguistic anthropology in order to better understand factors that influence health and well being (Scotch, 1963). That tradition may be said to be situated in the intersection between anthropology and (social) medicine, and derives its methodological and theoretical foundations from social anthropology and its thematic areas from medicine (Ingstad, 2007). In contrast, the German-Continental tradition of anthropological medicine draws on philosophy and the humanities (“the Geisteswissenschaften” to use the German word) in its theoretical inquiries about health and disease. The terms “medical anthropology” and “anthropological medicine,” used interchangeably throughout this text, refer to this latter tradition.¹¹

Many scholars representing the tradition of anthropological medicine were practicing physicians with a broad interest in the humanities. Main contributors to this tradition, in addition to Viktor von Weizsäcker, include Ludolph Krehl, Richard Siebeck, F.J.J. Buytendijk, Viktor Emil von Gebssattel, Herbert Plügge, and Paul Christian. In their practice of “philosophically rethinking medical activities” (ten Have, 1995, p. 8) they were inspired by phenomenology, existentialism, and philosophical anthropology, and by such thinkers as Edmund Husserl, Maurice Merleau-Ponty, Jean-Paul Sartre, and Max Scheler (ten Have, 1995; Spiegelberg, 1972), as well as by Sigmund Freud (Rorarius, 1991; Verwey, 1990).

Drawing on different theories and perspectives, von Weizsäcker and the other representatives of this tradition do not present a clear-cut theory. Rather, they represent a “family of ideas” focusing on basic problems within philosophy of medicine, including the rejection of Cartesian dualism, the model of medicine as science of the human person, and the necessity of a comprehensive understanding of disease (ten Have, 1995). The critique of a dualistic and reductive approach to the human being and to the human body is central to this anthropological tradition. One of their main interests was to redefine and reinterpret medicine as a science of man, arguing for a more humanistic foundation of medicine: “Anyone who suffers from a disease, who recovers or dies, is a human being, i.e. a natural creature and at the same time a person,” the Spanish medical historian and proponent of

¹¹ Another term that is also used in connection with this field of inquiry is the term “Theoretische Pathologie” or theoretical pathology. As I understand it, theoretical pathology coincides with the tradition of anthropological medicine, reflecting the similar field of inquiry. This is also emphasized by Eduard Seidler and Wilhelm Doerr (Seidler, 1984) and Paul Christian (Christian, 1989).

anthropological medicine Pedro Laín Entralgo writes in an essay treating the “structure and content” of a medical anthropology (Entralgo, 1984, p. 92).¹² This has further implications for the choice of methods, and entails that the methods of the natural sciences are not fully adequate. “To examine the living being, we should participate in life, and focus upon the purposeful coherence and interrelationships, the significance of experience and conduct,” ten Have (1995, p. 10) writes, thus paraphrasing the well-known statement of von Weizsäcker that “in order to explore the living, one must engage oneself with life” (“Um Lebendes zu erforschen, muß man sich am Leben beteiligen”) (von Weizsäcker, 1997, p. 83). This illuminates another central aspect of anthropological medicine: its focus on the patient’s individual *biography*. By focusing on the patient’s narrative and biography, and by employing philosophical and hermeneutical, as well as historical, approaches, the methodological repertoire of this tradition differs from the methodologies typically employed in biomedicine.

The starting point for my engagement with von Weizsäcker is his essay “Der Arzt und der Kranke” (von Weizsäcker, 1987a; Solbakk, 1995, pp. 78–80). In this essay he formulates a basic starting point or “Urphänomen” for the theory and practice of medicine. This “Urphänomen,” “the ill human being, who is in need [Not], who needs help, and, who therefore contacts the physician” (von Weizsäcker, 1987a, p. 13), represents in many ways the hub from which my reading and working with von Weizsäcker’s texts emanates. His demand for a “metaphysics” of the ill and for a medicine that also “teaches the ill human being” (von Weizsäcker, 1987a) represents important pegs that have helped to structure my reading of his texts. Says von Weizsäcker:

The physics (and psychology = the physics of the soul) of the ill is not his metaphysics, his appearance is not yet his essence. Where is it comprehensible? It is so *close* that the distanced microscopic or macroscopic look overlooks it; the objective look strains the eye when it comes to the sense of hearing: it *resounds in the plea for help*. (Von Weizsäcker, 1987a, p. 13)¹³

¹² “Wer an einer Krankheit leidet, wer gesundet oder stirbt, ist ein Mensch, d.h. ein natürliches Wesen und *zugleich* Person” (Entralgo, 1984, p. 92).

¹³ “Die Physik (und Psychologie = Physik der Seele) des Kranken ist nicht seine Metaphysik, seine Erscheinung ist noch nicht sein Wesen. Wo ist es fassbar? Es liegt so *nah*, dass die mikroskopisch oder makroskopisch zu ferne Optik es übersehen lässt, dass die objektive Optik das Auge anstrengt, wo es auf das Gehör ankommt: *es tönt in der Bitte um Hilfe*” (von Weizsäcker, 1987a, p. 13).

As I understand his use of the term “metaphysics” here, it is more a metaphor than a reference to the philosophical branch of metaphysics. Asking for a perspective on the ill human being that reaches beyond the purely physical aspects of disease, he uses the term “metaphysics” to denote this “beyondness,” alluding to the illness dimension of medicine and more specifically to the ill-being (“das Kranksein”) of the patient. His quest for a metaphysics of the ill also involves, as I understand it, an ethical demand for physicians to be able to capture the patient’s *need* that manifests itself as “a plea for help” (von Weizsäcker, 1987a, p. 13). So I have chosen to focus my reading on the pathic and on pathic existence, with less attention to the other main parts of his works, such as his emphasis on biography and the biographical method, or his contributions in psychosomatics. For this reason I will not pursue any of the Freudian influences on his work. I also abstain from an in-depth analysis of his conceptualization of the “Gestaltkreis,” considered to be one of his main theoretical contributions to psychosomatic theory (von Weizsäcker, 1997).

2.1.2 Toward a metaphysics of the ill: Pathic existence and “Kranksein”

Viktor von Weizsäcker is not considered part of the phenomenological movement. But his works may be interpreted within a phenomenological frame of reference. Calling for a metaphysics of the ill, he puts emphasis on the ill-being of the patient, and his conceptualization of pathic existence may be interpreted in terms of phenomenology, providing a description of lived experience. His understanding of the pathic may also be read as an expression of the general phenomenological idea that existence becomes apparent through a break with what is ordinary and taken for granted in our existence. He points to a certain similarity between his own expression of “pathische Umgang” (pathic dealings) and Heidegger’s “existentials.” He finds Heidegger’s concept of “being cast out in time” (“Geworfensein des Daseins in die Zeit”) restricted, and instead prefers his own conceptualization of “pathische Umgang” (von Weizsäcker, 1988b, pp. 555–556). His understanding of the pathic modes of the human being converges with phenomenological ideas related to the biological phenomenological approach of F.J.J. Buytendijk, who also specifies various human modes of being in his *Prolegomena to an Anthropological Physiology* (Buytendijk, 1967). In paper 3 I also point to the resemblance between the “pathic landscape” of von Weizsäcker and the existentialism of Jean Paul Sartre and Søren Kierkegaard (Martinsen, E. H. & Solbakk, 2012).

Von Weizsäcker's most elaborate treatment of the pathic is in his last work, *Pathosophie* (von Weizsäcker, 1967). The term "pathosophie" may be intended to express the "wisdom of suffering" ("Weisheit des Leidens") (Rorarius, 1991). By introducing the concept of the pathic, von Weizsäcker aims to turn medical anthropology into a "pathic anthropology" (von Weizsäcker, 1967, p. 62), illustrating how human life distinguishes itself through its pathic mode of existence. The Greek term *pathos* incorporates suffering, but also has embedded in it implications of passion as conceived of by the Stoics. The Stoics regarded the movements of the mind—that is, the passions—as ailments disturbing the balance of the soul (Eriksson, 2008). This duality between suffering and passion is also characteristic of the concept of the pathic. In this conceptual vocabulary, "pathic" is contrasted with "ontic." The pathic does not denote the given, that is, being; rather, it expresses the part of biological existence that does *not* present itself as something already settled, but as something that *is not*, and which comes to expression through modal verbs such as "will," "can," "may," "shall," and "must." For this reason, the pathic is "non-ontic." Thus, for instance, when we say that we *will* something, this implies that that which is willed, *is not yet* (von Weizsäcker, 1967, 1987c). Our interactions with the world and with each other are characterized by a striving, a drive for that which is not; a feeling of being incomplete rather than complete, undetermined rather than determined, temporal rather than eternal. Von Weizsäcker also uses expressions like "pathic fluctuation" ("pathische Fluktuation") and "the floating layer of the pathic man" ("die Schwebelage des pathischen Menschen") to express this dynamic (von Weizsäcker, 1967, pp. 58 and 63). He also uses the image of a landscape through which we travel to denote the pathic, an image that presents the pathic as a forward directedness, a striving for that which is not (yet) (von Weizsäcker, 1967, p. 57). This way of conceiving of human existence von Weizsäcker expresses as an "antilogic of life" (von Weizsäcker, 1987c). According to von Weizsäcker, life is antilogical in the sense that it is

a significant contradiction ... whereby something neither *is* nor *is not*, but rather more precisely, loses being and simultaneously receives one. ... An antilogical state of affairs is ... such that both an assertion and its negation are true. ... If, for instance, I say "I am becoming," and at the same time I say "little by little I am dying," both things are true. ... *The living is always something permanent that*

changes—like the human being.” (von Weizsäcker, 1987c, p. 50, translated by Greco, 2009, pp. 36–37)¹⁴

In the German language, the modal verbs of “dürfen,” “müssen,” “sollen,” “können,” and “wollen” reveal the ambiguities and unsettledness that life, thus understood, displays (Greco, 2009). The pathic categories are terms that indicate existence not so much as it is given, but as it is *undergone* (“erlitten”), pointing to a reality of possibilities beyond the actual, beyond what is objectively the case at any given moment: “If I say ‘I want,’ the implication is that what I want is not already there; if I say ‘I can,’ I similarly imply that what I can do may not come to pass.” (von Weizsäcker, 1987c, translated by Greco, 2009, p. 37)¹⁵

In paper 3 I investigate illness by making use of these five verbs as they are elaborated upon by von Weizsäcker. The modal verbs are used to indicate modality; they give information about the function of the main verb to which the modal verb is related, and are used to express such ideas as possibility, obligation, and necessity. Mode means “way,” understood as the way something is, or the state one finds oneself in. We may talk about ways of being, ways of acting, ways of experiencing, ways of thinking. F.J.J. Buytendijk writes of “exemplary modes of being man” in his *Prolegomena* (Buytendijk, 1967). He understands modes or moods as “ways of being,” and he writes of his “exemplary modes” include being-awake, and of being-sleep, of being-tired, -hungry, -thirsty, -labile, and -emotional. However, while Buytendijk elaborates physiological ways of being, von Weizsäcker is preoccupied with “pathological” ways of being, that is, with ill-being (“Kranksein”). For this reason I suggest using the pathic categories of von Weizsäcker to reflect different *modes* of ill-being. These categories mirror the pathic existence—the pathos of life—to which experiences of pleasure and suffering (“Lust und Leid”), and of joy and pain, belong (Wiehl, 1990). The categories are described as “passions (‘Passionen’), emotions (‘Affekte’) or desires (‘Leidenschaften’)

 that one has held on to in the flight and which are

¹⁴ “Überhaupt ist das Leben ein sinnvoller Widerspruch. ... in der etwas weder *ist* noch etwas *nicht ist*, sondern ein Sein gerade eben verliert und zugleich ein Sein gerade bekommt. ... Ein antilogischer Sachverhalt ist aber ein solcher, in welchem sowohl eine Aussage wie ihre Verneinung wahr sind, ... Wenn ich z.B. sage ‘ich werde...’ und zugleich sage ‘ich vergehe...’, dann ist beides wahr. ... *Immer ist das Lebendige ein veränderliches Gleichbleibendes – wie der Mensch*” (von Weizsäcker, 1987c, p. 50).

¹⁵ “Wenn ich sage, dass ich etwas will, so enthält dies geradezu die Konstatierung, dass das Gewollte *nicht ist*. Wenn ich sage: ich kann, dann ist ebenfalls darin enthalten, dass das, was ich kann, nicht ist” (von Weizsäcker, 1987c, p. 49).

forced into a concealed grammatical form” (von Weizsäcker, 1967, p. 61). Thus, the pathic is on the one hand connected to passions, emotions, and desires, and on the other hand, it is connected to suffering and illness. I will not go into each of the categories here since this will be done in paper 3. However, to complement the understanding of the pathic in relation to illness and ill-being, I provide a further example that I take from Oliver Sacks’s book *A Leg to Stand On* (Sacks, 1991).

2.1.3 The pathic mode of suffering from a ruptured quadriceps femoris muscle

In this autobiographical book, Sacks describes his own experience of not being able to use one leg after having suffered a rupture of the left quadriceps femoris muscle while hiking in the Norwegian mountains. Says Sacks:

There, it seemed to me, I willed—and nothing happened: so that I was forced into a singular doubt, and kept asking myself “Did I will? Have I will? What has happened to my will?” ... An accident of physiology, an injury, had deprived me of will—specifically and solely in relation to the injured limb.” (Sacks, 1991, p. 97)

Here, Sacks vividly describes the mode of wanting something that is not possible, as he tries to use his injured leg. Wanting to stand on the leg is not enough. Thus, he “willed, and nothing happened” (Sacks, 1991, p. 97). Sacks’s mode of wanting to be something that he is not, that is, healthy, thus reflects the pathic striving of his situation. Says von Weizsäcker:

The ill says by appearance and by words “I want to get well.” He *is not* what he wants to be. The wish, hope and intention that the one who is ill experiences by not being what he wants to be (i.e healthy), reflects the pathic situation of our existence. (Von Weizsäcker, 1988b, p. 554)¹⁶

Sacks’s wanting-to (“wollen”), however, is restricted by his not being able-to (“können”); he wants to walk, but he cannot because of his injury. “The ‘will’ was unstrung, precisely as the nerve-muscle” (Sacks, 1991, p. 96). This illustrates how the categories or modes are interrelated, and how they influence and interact with each other.

¹⁶ “Der Kranke sagt es schon durch sein Erscheinen, oder sogar ausdrücklich mit Worten: ‘Ich möchte gesund werden.’ Er *ist* also das *nicht*, was er werden möchte. Das ist die pathische Situation unseres Daseins, die hier der Kranke als Wunsch, Hoffnung, Absicht erfährt: er möchte nicht sein, was er ist, sofern er krank ist” (von Weizsäcker, 1988b, p. 554).

At the hospital, Sacks is encouraged by his physiotherapist to try to walk on the leg that was operated on. He knows it is possible, because he had used the leg before the accident. And being a physician himself, he also knows that it is possible to use the leg after an injury like this, given the right treatment. However, in this situation Sacks gives expression to the feeling that he cannot; that this possibility is (at present) impossible for him:

How could I stand, without a leg to stand on? How could I walk, when I lacked legs to walk with? How could I act, when the instrument of action had been reduced to an inert, immobile, lifeless, white thing? How *could* I walk, how *could* I stand on, let alone move, a ghostly lump of jelly, a nothing, which hung loosely from my hip? And even if, supported by its carapace of chalk, this preposterous appendage *could* support me, how then would I “walk” when I had forgotten how to walk? (Sacks, 1991, pp. 99 and 103)

The mode of “können” or, more accurately, of “nicht können,” reflects the hypothetically conceivable, this that *could be*, but is not yet, as is clearly reflected in this case where Oliver Sacks is unable to do what he previously was able to: namely, to walk on his leg. Eduard Seidler points in his work to the situation of “cannot anymore” (“nicht-mehr-können”) as a primary experience of illness (Seidler, 1978; Elstad, 1987). The “nicht-mehr-können” is constituted by our relation to our own body and bodily experience, and is often marked by helplessness and frailty (“hinfälligkeit”). Drawing on Seidler, Ingunn Elstad further differentiates between two different aspects of the helplessness and frailty of the “nicht-mehr-können”: First, she points to the exertion and the striving of the ill trying to deal with or overcome the “nicht-können.” Second, she points to the surrender characterized by a “I cannot anymore,” by which the ill draws him- or herself back from the surroundings (Elstad, 1987). Similarly, Virginia Woolf (2002) writes in her essay *On Being Ill* about how those who are ill often prefer solitude. “Here we go alone, and like it better so,” she writes (p. 12). Those who are ill become part of the world of the recumbent, lying flat in solitude in the sick room:

Directly the bed is called for, or, sunk deep among pillows in one chair, we raise our feet even an inch above the ground on another, we cease to be soldiers in the army of the upright; we become deserters. (Woolf, 2002, p.12)

In the withdrawal and surrender there is no clear boundary between the “nicht-können” and the “nicht-wollen” (Elstad, 1987). In “nicht-können” we are not able to do anything, and we do not want to do anything, either, because we do not have the strength. Here we see how “nicht-können” and “nicht-wollen” intertwine: Our “wollen” is influenced by our “nicht-können” in such a way that we may not want what we are not able to do. However, this may also go the other way around, as we saw in the example of Oliver Sacks, where “wollen” is highly important in the process of rehabilitation. That is, Sacks’ wanting to use his leg again may be decisive for his ability to being able to (“können”), in order to make the impossible possible.

We see from this how “wollen” and “können” influence each other in what von Weizsäcker denotes as the *pathic pentagramme* (Von Weizsäcker, 1988a; Rimpau, 2011). The pathic pentagram represents the mutual relationship and interaction among the five pathic categories, where they modify and color each other. In another example, “müssen” may be modified by “wollen” in that it may be different if we want to do what we have to do, rather than if we do not want what we are obliged to do. This may be the case, for instance, when a patient is told by the physician that he *has to* (“müssen”) stop smoking in order to avoid serious deterioration of his health, and where the patient’s having to is highly dependent on whether he *wants to* (“wollen”) quit smoking or not. These different nuances inflect the patient’s ill-being, and may furthermore inflect the therapeutic possibilities. Fichter (2007) points out how psychotherapeutical work often is about helping patients move from “müssen” to “wollen.” The therapist must try to give the patients the confidence to believe that they can and that they shall endure and make use of their own resources, as well as remembering what they already could, and earlier have, accomplished (Fichter, 2007). However, to move between the patient’s “müssen” and his or her “wollen” is always the patient’s own decision, and it is through this decision that “wollen” may grow from “müssen” (Fichter, 2007).

Through this meditation on the interrelation of modal verbs I have tried to illustrate that von Weizsäcker’s understanding of the pathic and of pathic existence may illuminate important aspects of ill-being. In this way he fulfills to a certain extent his ambition of arriving at a conception of medicine that also deals with the human being in need, the *homo patiens*. However, von Weizsäcker’s conceptualization of the pathic implies more than an understanding of the pathic subject as ill, as a patient; it also has implications for an

understanding of the human being and of human existence *as such*, by the inclusion of illness in his understanding of the human being qua human (“als eine Weise des Menschseins”). His understanding of illness as “a way of being human” is thus related to his understanding of the pathic, the “antilogical” way of understanding our existence, in which life and death are intrinsically linked (von Weizsäcker, 1988b):

Always, death is not only an opponent of life but a part of life itself, and without it life would not be life. If being ill is a way of being human, then it has a full share in the real identity of life and death, and in the intertwining of downfall and ascent. (Von Weizsäcker, 1988b, pp. 612, 615)¹⁷

This general “positive” attitude toward both ailment and death in relation to our lives further reflects a key theme in his pathosophical project: namely, the understanding of human ailment and the inevitable outcome of death as being deeply embedded in the human condition. Our lives and our existence in general are comprised more of ailment than of health. Says von Weizsäcker:

Which bodies are spotless? ... Which family is free from hereditary damage? Which biography is undisturbed by disease? Which mental life is free from neuroses or pathological conditions or characteristics? ... He who regards himself as completely fit and healthy is just blind to that which is pathological. (von Weizsäcker, 1967, pp. 8–9)¹⁸

Ailment is thus given existential primacy over health. Von Weizsäcker’s understanding of our existence as an interaction or “Umgang” with death and illness differs from much of the phenomenological literature dealing with illness, such as the works of illness phenomenologists including Fredrik Svenaeus (2000, 2009, 2011), Kay Toombs (1988),

¹⁷ “Immer ist der Tod nicht nur ein Gegenspieler des Lebens, sondern ein Teil des Lebens selbst, ohne den Leben nicht Leben wäre. ... Wenn Kranksein eine Weise des Menschseins ist, dann hat es vollen Anteil an der wirklichen Identität von Leben und Tod, Anteil auch an der Verschlungenheit von Untergang und Aufgang” (Von Weizsäcker, 1988b, pp. 612, 615).

¹⁸ “Welcher Körper wäre makellos gebildet? ... Welche Familie ist frei von erblichen Schäden? Welche Biographie ungestört durch greifbare Erkrankung? Welches Seelenleben frei von Neurose oder pathologischen Zuständen oder Zügen? ... Wer sich für völlig gesund hält, der ist nur blind für das Pathologische” (von Weizsäcker, 1967, pp. 8–9).

Drew Leder (1990), and Havi Carel (2008, 2011). Those authors explicate illness as a form of alienated or unhomelike being, as a “disruption” or a “dys-appearance,” in contrast to von Weizsäcker’s emphasis on the reciprocity of illness and death in our existence.

This is an interesting discussion, which I pursue in paper 3. However, to go further into this here would be beyond the scope of this thesis. Therefore, I will refrain from a more comprehensive discussion of the illness perspective of von Weizsäcker, and instead will move on, having indicated the basic phenomenon as my point of departure. Instead I continue to explore the *homo compatiens* in terms of care rather than pursuing further the phenomenology of illness. Nevertheless, a further exploration of the illness perspective of von Weizsäcker in relation to similar perspectives within the field of the phenomenology of illness represents an interesting area for further research that emanates from this thesis.

2.1.4 Critical remarks

The scientific value of the Heidelberg variant of psychosomatics, first and foremost the contribution of Viktor von Weizsäcker, has been assessed differently. Without mentioning names, Gerlof Verwey comments on an “uncritical acceptance and admiration” that pervades much of the literature on von Weizsäcker (Verwey, 1990, p. 147)—an admiration that he does not share. On the other hand, von Weizsäcker’s works have also been perceived as both unscientific and speculative, and as representing a “retrograde step to the level of pseudo-science” (Verwey, 1990, p. 148). There has been a severe critique of the Heidelberg variant of psychosomatics from the field of psychiatry. The criticism was primarily directed against the biographical-historical (meaning) perspective on disease, and an uninhibited tendency to psychologize, interpreting mental disorders, both neuroses *and* psychoses, as expressions of life crises (H.J. Weitbrecht, referred to in Verwey, 1990, pp. 148–149).

Karl Jaspers, psychiatrist, philosopher, and contemporary of von Weizsäcker, was critical of medical anthropology in general, and the pathosophy of von Weizsäcker in particular. As I point out in paper 3, Jaspers rejected medical anthropology as such, pointing to its concurrence with philosophical anthropology (Martinsen, E. H. & Solbakk, 2012). He was also very critical of von Weizsäcker’s use of medical cases, and of his method of using biographical explorations of psychosomatic diseases, thus apparently looking for the “explanation” in the patient’s biography (Jaspers, 1997). “His case-histories can be read with some wonder; it seems that anything is possible, but in the end we know as little as

when we started,” Jaspers writes (1997, p. 246). Jaspers is not only critical of the cases that von Weizsäcker uses, but also of the way he interprets cases of physical disease, for instance, tonsillitis or micturition dysfunction, in psychoanalytic terms (Bormuth, 2008). Since these aspects of von Weizsäcker’s work are not relevant to my thesis, this critique may not be particularly relevant here. However, in my view, as a reader of von Weizsäcker today, there is little point in reading him so concretely and literally. This certainly applies when it comes to his interpretation of tonsillitis as a reaction to an erotic conflict. I thus agree with Jaspers that von Weizsäcker’s understanding of how the patient’s biography may be said to work on a cellular level is both highly unrealistic and speculative. What I do find valuable in what von Weizsäcker writes about biography, about the biographical method, and about the meaning of diseases, however, is his emphasis on considering more than pure pathophysiology in the attempt to understand human disease. This is what I find innovative in his emphasis on biography, which he published 20 years before the American psychiatrist George L. Engel launched his biopsychosocial model (Engel, 1977, 1981).

The tradition of medical anthropology has also been criticized for showing a tendency towards *paternalism*.¹⁹ This criticism may also apply to some of the works of von Weizsäcker, where his emphasis upon pathic subjectivity, with its connotation of passivity, may be said to be out of tune with the development of medicine, particularly since the 1960s, when there has been an increased focus on “activity, intervention, control, and manipulation” (ten Have, 1995, p. 12) as well as on patient autonomy and patients’ rights. I address this critique in paper 3, asking whether it is at all relevant to talk about modals like “dürfen” and “sollen” in modern health care. In that paper I point to the importance of these modes of ill-being in today’s medicine despite its current focus on patient autonomy and patient participation (Martinsen, E. H. & Solbakk, 2012). By not acknowledging the aspect of permission (“dürfen”) inherent in ill-being, we may get an unrealistic picture of illness and of the state of being ill, I argue. Illness does not consist only of conditions that we may be “empowered” from, or make autonomous choices in relation to. This is illustrated in paper 3 by the situation of Nicole, who is going through bone-marrow transplantation. For

¹⁹ The notion of paternalism is often referred to as the interference of a state or an individual with another person, against their will, and defended or motivated by a claim that the person interfered with will be better off or protected from harm. In a medical context the issue of paternalism arises, for instance, by the withholding of relevant information concerning a patient’s condition by physicians, or by physicians doing what they think may benefit the patient without asking for the patient’s consent (“Paternalism,” *Stanford Encyclopedia of Bioethics*).

this treatment to be successful she has to (“müssen”) follow the physicians’ advice exactly, and not leave the isolation ward before she is allowed to (“dürfen”). In this situation Nicole does not have any choice but to follow the medical prescriptions and do as she is told, unless she wants to diminish her own chances of survival. Accordingly, “being allowed” in this situation reflects a central dimension of Nicole’s being at this time, and does not necessarily count as an expression of medical paternalism.

Being part of the pathic pentagram, “dürfen” is colored by the other categories. For instance, there is a connection between what we are allowed or not allowed to do and what we have to do (“müssen”). That is, there may also be a hidden command in a permission that is granted. We see this element of hidden command, for instance, in the newly post-surgical patient who is “allowed” to get out of bed, meaning she has to (“müssen”) get up in order to prevent the development of postoperative thromboembolic disease. Here we see the ambiguity of being allowed: Being a patient, we are subordinate to the medical experts, and if we are “good patients” we behave only as we are allowed to. The medical experts, on the other hand, expect us to do as we are allowed, and in this expectation there is also an element of hidden command. This ambiguity of being allowed and of being commanded represents thus an interesting and important aspect of ill-being, which I believe may be underestimated in today’s medicine and medical ethics. Taking the elements of “dürfen” and “müssen” into consideration in relation to illness and ill-being may contribute to a more nuanced discussion of patient autonomy in modern health care. Even though we emphasize patient autonomy and patients’ rights, the elements of permission and command are still inherent in the patient’s act, being in a vulnerable state, of seeking help from an expert, whose advice she ought to follow in order to get well.

Was von Weizsäcker’s understanding and elaboration of the pathic existence influenced by his historical moment? May his understanding of illness and suffering as ways of being human have been conditioned by the time in which he lived, characterized by the terrible events of war?²⁰ I have tried to relate his thinking regarding the pathic to the phenomenological tradition, pointing to how his understanding of pathic existence may be understood more as an expression of the general phenomenological idea that existence becomes apparent through a break with what is ordinary and taken for granted in our existence. In paper 3 I also point to a resemblance between the “pathic landscape” of von

²⁰ I thank Jens Erik Paulsen for asking me this question.

Weizsäcker and the existentialism of Jean Paul Sartre and Søren Kierkegaard. In these works as well, human existence may be perceived from the vantage point of negative phenomena such as illness, anxiety, despair (Kierkegaard, 1980, 2004), and deficiency, lack, absence, and nothingness (Sartre, 1956). By contextualizing his works within the intellectual movements of his time, I think we may argue that von Weizsäcker, rather than reacting only to the actual life circumstances of his time, was also inspired by and possibly influenced by the intellectual currents of his time.

To sum up, I have tried to clarify how von Weizsäcker's understanding of pathic existence and of pathic subjectivity may illuminate important aspects of ill-being. I have approached the principal objective of the thesis from the angle of the ill human being, the *homo patiens*, by pointing out theoretically important aspects related to the experience of being ill. I have taken von Weizsäcker's understanding of the pathic as my point of departure, ill-being conceived of as pathic being, and expressed through the pathic modals of will, may, shall, can, and must.

I continue my exploration of this basic phenomenon by analyzing the physician as a medical helper (*homo compatiens*), following von Weizsäcker's conception of medical anthropology, which demands a perspective on the medical helper as well as on the human being in need (von Weizsäcker, 1987a). I expand on this to involve the perspective of care in medicine, thus situating the medical helper within the framework of care philosophy and care ethics. The exploration starts by crossing the border into the field of nursing and the care philosophy of Kari Martinsen.

2.2 Thinking with Kari Martinsen in medicine

My point of departure for my exploration of care is the philosophy of care developed by the Norwegian nursing scientist and philosopher Kari Martinsen. Martinsen (2003a, 2003b, 2003c, 2006) develops her concept of care as a way to comprehend the relationship between the patient's illness experience and the nurse or health care professional who is there to help. She elaborates on the claim that the patient's subjective condition of disease lays on us as health care professionals. In this, we see a resemblance to the perspective of von Weizsäcker, with his emphasis on the basic phenomena of the person in need and the person as helper. Both von Weizsäcker and Martinsen are concerned with the patient's suffering or

need (“Not”), and how this suffering acts on the physician or nurse to elicit some kind of response.

In what follows I elaborate on Martinsen’s contribution to understanding the fundamental relationship between a human being in need and a human being as helper. I focus on her phenomenological analysis of care, and her understanding of perception and its relevance and importance for the medical encounter; discuss her conceptions of “perceiving” and “recording”; and present some objections to and criticisms of her theoretical position. First, however, I consider Martinsen’s concept of care, focusing on her three dimensions of care.

2.2.1 The three dimensions of care

In her early analyses of care, Martinsen introduces three dimensions of care: the relational, the moral, and the practical (Martinsen, 2003a). “Care has to do with relations and morality, and it expresses itself through practical action,” she writes (1989, p. 208).²¹ In her early attempts to grasp the essence of caring, Martinsen relies on Martin Heidegger and his understanding of “Sorge.” Later, however, she comes to reappraise Heidegger, pointing to the difficulty of combining his thinking with a philosophy of care due to the influence on him of National Socialistic ideology during World War II (Martinsen, 2003a). To fill the theoretical void left by her rejection of Heidegger, Martinsen turns her attention to the phenomenological writings of Knud E. Løgstrup. As she moves from Heidegger to Løgstrup, the moral aspects of care become more important for Martinsen. She also deepens the analysis of care phenomenologically, focusing on the lived experience of care and concern, and the role of moral sensibility in it.

Martinsen emphasizes a *relational* dimension of care: As human beings we are fundamentally social and dependent on other people. Her position is thus opposed to an individualistic view that would picture human beings as primarily independent and self-sufficient. Here Martinsen relies on the Danish philosopher Uffe Juul Jensen and his formulation of *the moral principle of responsibility for the weak* (Martinsen, 2003a).²² Both Juul Jensen and Løgstrup consider human beings to be dependent upon fellowship with others for human growth and flourishing. This reflects the *relational* dimension of care.

²¹ “Omsorg har å gjøre med relasjoner og moral, og den ytrer seg i praktisk handling” (Martinsen, 1989, p. 208).

²² “Det moralske prinsipp om ansvaret for de svake” (Martinsen, 2003a).

Caring is also *moral*, and has to do with how we *are* in relation to other people through our practical work. The moral dimension of care is tightly connected to the relational and practical dimensions: Caring is what happens “in between” human beings: “Care is to interconnect, to be part of relations” (Martinsen, 1989, p. 183).²³ Furthermore, care is carried out by practical action: “we enter morality by practical action” (Martinsen, 1989, p. 187). That care is *practical* means that care involves practical, immediate, and other-oriented actions in concrete circumstances. Care is exercised, trained, and learned through its practices of concern for other persons (Alvsvåg, 2006). These three dimensions of human care have remained central to Martinsen’s position ever since she first posed them. Even though she has occasionally relied on different philosophers and traditions in analyzing care, and her argumentation has developed over time, that does not mean that her arguments are not consistent (Gjengedal, 2000).

2.2.2 A phenomenological approach to care

In relying on the Danish philosopher and theologian Knud E. Løgstrup, Martinsen anchors her phenomenological analysis of care in the tradition of “phenomenology of creation” (“skapelsesfenomenologien” in Norwegian) (Martinsen, 2003c). This tradition has its roots in a Jewish-Christian view of human life and creation. According to Jewish-Christian anthropology, there is a created meaningful structure and architecture in life itself; life has an intrinsic significance, which shows itself in human relationships. The basic conditions of life are given to us, and are not a result of any of our human efforts and achievements. To understand life as created implies a radical change of perspective on the relation of myself to the other, Martinsen (1991) says. It allows for an attitude of holding oneself in reserve, and of “receiving the other as a gift” (Martinsen, 1991, p. 9). By this we allow the other to emerge in his or her own right, without “conquering” him or her. This reserve and receptivity Martinsen understands as part of what she means by our *perception*. Within a phenomenological frame of reference, Martinsen’s use of the term “perception” is related to the general idea of phenomenology as “open to the world.”

A word may be necessary about her use of the terms “perception” and “perceiving.” Martinsen mainly writes in Norwegian. However, the essay “Seeing with the Heart’s Eye,” which I rely on in this thesis, is published in English as well (Martinsen, 2006). In this essay Martinsen distinguishes between the processes of perceiving and recording. If we compare

²³ “Omsorg er å knytte bånd, å inngå i relasjoner” (Martinsen, 1989, p. 183).

the English version of the essay with the Norwegian version, we see that the English word “perceive” corresponds to the Norwegian word “sanse,” and “the perceiving eye” corresponds to the Norwegian expression “det sansende øye” (Martinsen, 2000). The word “sansning” is thus translated as “perception.” It is important not to confuse this way of understanding the term “perception” with the way it is used, for instance, in the field of psychology, where it refers to how we organize the sensory world into a coherent scene consisting of real objects, not just sensory impressions (Gleitman, 1992).

According to Martinsen, perception is characterized by an openness toward the world in which sensation and emotions are working together. It represents a “fundamental openness towards the world, significant and precultural” (Martinsen, 2006, p. 86). This understanding of perception clearly shows the influence of philosophical phenomenology on her thinking about care. In Edmund Husserl’s transcendental phenomenology, and also in his theory of time-consciousness, a central theme is how consciousness is constantly modulated by impressions; the claim is that we have a pre-theoretical affective access to the world that is conditioned by receptivity and passivity. Husserl claims to have an “axiological intuition” of the existence of this mode of perceptual function (Drabinski, 2001). Consciousness and sensibility do not constantly interpret and reflect on data, but in a state of passivity can be receptive to data given by impressions—a function that phenomenologists call the “impressional sense.” Martinsen bases her ethics of care on illustrating this kind of receptivity and openness to impressions in the physical and mental encounter between a nurse and a patient.²⁴

2.2.3 Perceiving and recording

This openness and receptivity constitute a central part of Martinsen’s understanding of perception, and characterize what she calls “the perceiving eye” (Martinsen, 2006). The

²⁴ I would like to thank Per Nortvedt for help with clarifying this point. Drawing on the work of Emmanuel Levinas, Edmund Husserl, and John E. Drabinski, as referred to above, Nortvedt describes a state of “sensibility,” which he understands as “the basic state of pre-intentional consciousness characterized by passivity and receptivity” (Nortvedt, 2008a, p. 211). Sensibility may be understood as a presence in the world through our senses, where not only our interpretation of impressions but also the impression in itself is important, moving both our senses and emotions. As I interpret Nortvedt here, I find his understanding of sensibility similar to Kari Martinsen’s understanding of perception and what she denotes as “the perceiving eye” (Martinsen, 2006). Even though they build on the work of different theoreticians, they both aim to grasp an openness to affective cues in the clinical encounter, an openness allowing for the vulnerability of the human other, which is necessary for competent medical treatment and care. Nortvedt argues in this regard that the affective part of moral sensitivity has significance for health care workers’ moral motivation, as well as for their clinical understanding.

perceiving eye opens for “a seeing emotion,” in which we are touched and emotionally involved even before we rationally understand the needs of the other (Martinsen, 2006). A central feature of the care philosophy of Martinsen is thus her emphasis on the importance of perception in all our interaction with others, including in clinical situations. According to Martinsen, professional care also relies on this basic understanding of care, emphasizing human openness and receptivity. However, in order to actually help the patient, these basic elements of care need to be supplemented by professional knowledge as an essential part of clinical judgment. According to Martinsen, then, clinical judgment consists of the basic quality of care as an open and spontaneous receptivity, as well as professional considerations: “Clinical judgment in nursing is an interpretive activity, by which professional knowledge and natural perception work together” (Martinsen, 2003b, p. 145).²⁵ It is tempting to emphasize only one of the two elements, she warns us; however, without professional knowledge, consideration for the patient may turn into *sentimental care*. Sentimental care, according to Martinsen, is care in which the caregiver’s participation in the other’s suffering is limited to the caregiver’s own sentimentality, to his or her own feelings. When the caregiver confines him or herself to pitying the patient and refrains from helping the patient in a professional manner, the care becomes *sentimental*. When care turns sentimental, we stop at “feeling sorry for.” “In sentimental care the other also disappears. I go emotionally ‘up’ into the other. The situation disappears. Our own feelings become the center of attention; they become void of content, they become ‘pure affectivity.’ ... This pure affectivity easily leads us to indifference,” writes Martinsen (1989, p. 202).²⁶ Sentimental care represents what Martinsen calls “the degeneration of care” (“omsorgens utartinger”) (Martinsen, 1989, p. 191).

In her essay “Seeing with the Heart’s Eye,” Martinsen explores different dimensions of the clinician’s gaze, drawing a distinction between the process of perception and the process of recording; between a *perceiving eye* and a *recording eye* (Martinsen, 2006). She relates these two different ways of seeing to the biblical story of the Good Samaritan, with which she illustrates how the perceiving eye can facilitate care in the clinical encounter. She

²⁵ “Skjønnnet i sykepleien er et tydningsarbeid hvor fagkunnskap og naturlig sansing arbeider sammen” (Martinsen, 2003b, p. 145).

²⁶ “I den sentimentale omsorgen blir også den andre borte. Jeg går følelsesmessig ‘opp’ i den andre. Situasjonen blir borte. Egne følelser settes i sentrum. Følelsene blir innholdsløse, de blir ‘ren affektivitet.’ ... Denne rene affektivitet fører lett over i likegyldighet” (Martinsen, 1989, p. 202).

contrasts that with the recording eye, the eye of the disinterested observer, in which the other as a person may become indifferent to us (Martinsen, 2006). Recording is when we put ourselves in an outside position, classifying, systematizing, and differentiating, working within the frameworks of an already existing conceptual system (Martinsen, 2006). The recording eye is reductionistic and neutral, and may reduce living characteristics, such as a laughing face, to clinical signs, characteristics, and marks. Says Martinsen:

For the disinterested, observing gaze is busy classifying and overlooks and does not hear the demand—to take responsibility for that [part] of the life of the other which we have in our gaze. The classification overlooks the demand. The concepts and their internal logical order block the way, so that we do not see the other as a living person. (Martinsen, 2006, p. 105)

Here Martinsen reiterates Løgstrup's well-known saying that we always hold some of other persons' lives in our hands, referring to the "life of the other which we have in our gaze."²⁷ Martinsen's description of the recording eye is inspired by Løgstrup's conception of the "eye of the epoch," which constitutes part of his critique of modernity (Løgstrup, 2008). She echoes as well the medical historical works of Michel Foucault and his analyses of "the medical gaze" (Foucault, 1994, 1995). Foucault coins the term "medical gaze" to refer to the dehumanizing way in which the medical profession has come to separate the body from the person. He argues that the emergence of clinical pathology in France in the late 18th and early 19th centuries marked the demise of humoral, Galenic, and empirical medicine. Its replacement, the developing medical gaze, focuses its attention on the object of the disease, rather than on the subject that suffers from it. The objects of disease consist primarily of the pathology of anatomical structures, and in this period dissection enjoyed something of a revival (Faber, 1930). Likewise, the rise of bacteriology in the second half of the 19th century undoubtedly fuels the synthesis of this gaze in medicine. Foucault analyzes the changes that occur in the way physicians *see* from the last half of the 18th century and into the beginning of the 19th century, and notes that this reflects a break in the thinking pattern and usual way of working of physicians. From having focused on overt symptoms and their classification, physicians start looking instead for processes of disease *in* the body of the

²⁷ In *The Ethical Demand* Løgstrup says: "Each individual has never to do with another human being without holding something of the other's life in his or her hand" ("den enkelte har aldrig med et andet menneske at gøre uden at han holder noget af dets liv i sin hånd") (Løgstrup, 1956, p. 25).

patient, and the gaze of physicians turns out to be “empirical classifying” as well as a “theoretical depth gaze” (Martinsen, 2008). Foucault describes the creation of a field of knowledge of the body, and clarifies how the material and intellectual structures that make possible the analysis of the body are admixed with power interests: In entering the field of knowledge, the human body also enters the field of power, becoming a possible target for manipulation. This new knowledge is then used in the political project of sorting the useful bodies from the useless, the productive from the non-productive, the sick from the healthy. Discipline, or the “art of distributions” (Foucault, 1995), becomes an important element in this knowledge paradigm, and is expressed in the formal examination of the patient. Central to this examination is the systematic observation of the patient, throughout which the professional is withdrawn in relation to the patient. This reflects an important implication of the medical gaze for medical practice: the tendency of the medical gaze to create or entrench distance between the physician and the patient, because the physician is now using a medical or clinical gaze to observe the patient’s symptoms and search for causes. The medical gaze thus literally objectifies a characteristic of the scientific method in the therapeutic dyad.

This element of professional distance and the striving for objectivity is part of what Martinsen calls the recording gaze: “The professional does not present himself as a person in relation to the patient. ... He gives nothing of himself in the relation. There is great power in this closedness” (Martinsen, 2006, p. 108). The recording eye is a way of seeing in which what Martinsen calls perception is lost, and through which objectivity and distance is sought. This gaze does something to both the professional and the patient, Martinsen argues: “It hinders both parties in presenting themselves and letting themselves be known as living and perceiving human beings” (Martinsen, 2006, p. 109).

I will return to these two ways of seeing later in the text, discussing them in more detail in relation to medicine and to the basic phenomena of the person in need and the person as helper, asking: What gaze is at work in medicine today?

2.2.4 Critical remarks

Kari Martinsen’s perspective is not uncontroversial. Since early in her career she has been subjected to serious criticism and disagreement. She was critical of the influence of American theories of nursing in Norway, especially the work of the American nursing

scientist Dorothea Orem, with her emphasis on “self-care” (Orem, Renpenning, & Taylor, 2003). Her criticisms of this approach were not well received by the Norwegian Nursing Association, which called on its members to boycott Martinsen’s work. Martinsen was asked at one point to leave the Norwegian Nursing Association—a request she refused.

Martinsen has been criticized for inheriting what one critic calls “an uncritical understanding of emotions as a professional competency in nursing” (Heggen, 2000). Even though we aim to be empathic and sensitive as nurses, we do not automatically act morally, Kristin Heggen claims in her article “Romanticizing Nursing” (Heggen, 2000). Emotions are not automatically a source of “truth and right.” As important as the positive effects of emotion is the need to deal with our negative feelings for patients as health care professionals. Heggen raises questions about the relation between our emotions and our moral conduct, as well as calling attention to the possible presence of darker emotions in our encounters with patients. How can we be certain that our open spontaneous feelings, our “seeing emotions,” actually lead to positive action? And what if we get angry or irritated with the patient, instead of feeling compassion? What if no spontaneous emotional response shows up in our meeting with a patient, and we just feel indifference? Is it always the case that we are struck, or hit in the guts, by being within “the perceiving range of life”?

Martinsen does not address the possible “dark sides” of emotions in her work, and she does not question whether we can be certain that our “seeing emotions” always see the other in a compassionate way. These objections certainly represent limitations of Martinsen’s theory. However, Martinsen is not a pure “sentimentalist,” highlighting only emotions. She also points to the importance of the reflectivity of our understanding, working in a “friendly interaction” with our perception. It is difficult to split this friendly interaction between perception and understanding; they are “tightly interwoven” (Martinsen, 2006, p. 87). In this, Martinsen is in line with most other care ethicists in acknowledging the cognitive as well as the affective dimensions of care, and she places herself within an influential movement in moral philosophy highlighting the importance of human emotions (Blum, 1994; Nussbaum, 1990; Vetlesen, 1994; Slote, 2007).

Heggen considers Kari Martinsen a “guide” to romanticizing practice within nursing: Nursing as a discipline “may be in danger of turning into a discipline of manners, by which the practitioners first and foremost are characterized by a *‘particularly well-developed sort*

of humanness.' That makes no sense" (Heggen, 2000, p. 48).²⁸ Instead, Heggen calls for an increased focus on professional skills and knowledge in nursing.

There is some justice in some of Heggen's criticism, and it may well be the case that nursing in Norway and Scandinavia has focused too much on the experiential side of nursing. However, I question whether Heggen's critique addresses Martinsen's actual position, or whether it is *the interpretation* of Martinsen's perspective within academic nursing that Heggen criticizes. As I read Martinsen, I find an emphasis on care as a *practical activity* as she points to how care expresses itself in practical action (Martinsen, 1989). She introduces us to the practical dimension of care in her works prior to her focus on Løgstrup, but this dimension is also evident in the work inspired by Løgstrup (Gjengedal, 2000; Martinsen, 1989). Following Løgstrup, she points out that we *enter* morality by practical action (Martinsen, 1989). "The thought descends" into the concrete and actual situation, being processed by the practical judgment. The challenge of care is to "descend" into the field of practice, and to be involved and present in the situation. Here Martinsen points to the importance of clinical judgment, so that the caring engagement will not "tip over" into sentimentality. Thus, clinical judgment is in a key position ("vippeposisjon" in Norwegian), Martinsen claims. It is always directed toward the concrete situation and engaged in situational analysis (Martinsen, 1989).

However, even though Martinsen emphasizes the practical aspects of care, she seldom or never says anything about the more morally problematic situations faced by clinicians, and she rarely treats situations where there is not just one moral appeal to respond to, but several appeals, or where relevant ethical values may conflict (Nortvedt, 2001). She does talk a lot about the basis of ethical choices in care, but says little or nothing about what the nurse actually should do to choose in the case of moral conflict. In such cases she simply refers us back to the moral and clinical judgment of the clinician. So Martinsen's perspective does not offer any kind of action guidance in relation to difficult ethical situations. This is a criticism that has also been raised about the usefulness of Løgstrup's philosophy in health care ethics (Holm, 2001).

²⁸ "... faget kan stå i fare for å bli et væremåtefag hvor utøverne først og fremst kjennes på en slags '*særlig velutviklet menneskelighet*.' Det gir ikke mening" (Heggen, 2000, p. 48).

Martinsen has also been criticized as promoting an *altruistic* motive for care (Hem, 2008; Pettersen 2008, 2011b). Altruistic care may imply self-sacrifice on behalf of the carer, Tove Pettersen argues, since such care is activated by the needs of the other (Pettersen, 2008). I agree that Martinsen's understanding of care in asymmetric relations has altruistic elements. Martinsen herself reminds us of who the main person in this relation is by referring to the story of the Good Samaritan: The main person is not the Samaritan, she argues, but the wounded man (Martinsen, 2010). Thus, care in an asymmetric relationship, where one party is a professional and the other party is in need of help and service from the professional, is altruistic insofar as the care of the professional is motivated and activated by the needs of the other.²⁹ Thus far, I agree with Pettersen. However, I do not agree that Martinsen's care perspective is altruistic in the sense that it necessarily *implies self-sacrifice*. In making this claim, Pettersen does not take into consideration the consciousness of limit inherent in the professional reflection that Martinsen emphasizes in relation to practical care work. As I see it, Martinsen's emphasis on professional reflection represents a way of drawing the line against boundless care in professional care work. A physician or nurse who devotes herself to one patient without considering the situation of other patients or the rest of the care personnel does not act professionally, and does not exhibit proper clinical judgment. Inherent in professional reflection, thus, is a *consciousness of limit*: We come to work and leave work at scheduled times, turning our responsibilities over to others. Even in the story of the Good Samaritan, we find that the Samaritan eventually leaves the wounded man in the care of the hostel's host.

Pettersen also criticizes Martinsen's understanding of "spontaneous care." Martinsen defines "spontaneous care" as "taking time to help people one meets by coincidence, people "carrying a heavy burden" (Martinsen, 2003a, p. 74). "Spontaneous care" can be understood as Samaritan behavior, Pettersen (2008) argues. By "Samaritan behavior," Pettersen understands "acts based on the ideal of providing unconstrained help to those in need regardless of the circumstances and without expecting reward or recognition" (Pettersen, 2008, p. 136). The story of the Good Samaritan should not be considered as a foundational story for an ethics of care, Pettersen argues, since a spontaneous distribution of care for the needy raises the problem of discriminating against those who happened not to be first in line. By devoting ourselves to the first needy individual to appear, we might neglect others

²⁹ However, I think a paid salary may also work as a motive in such a situation.

who are suffering more, as well as squandering all our resources on the first in line. Spontaneous care may thus inflict the “harm of discrimination” by discriminating against people who for various reasons are not first in line (P. Ariansen, referred to in Pettersen, 2008, p. 137). “Is it the most needy, poorest or sickest who are first in line? Or is it the most self-asserting, cynical and affluent? ... The distribution principle behind Samaritanism is ‘first come, first served,’ a principle that encourages neither care nor love of one’s neighbors” (Pettersen, 2008, p. 137).

As I noted above, Pettersen defines Samaritanism as “acts based on the ideal of providing unconstrained help to those in need regardless of the circumstances and without expecting reward or recognition” (Pettersen, 2008, p. 136). But by connecting this definition to Martinsen’s conception of spontaneous care, she to some extent misrepresents Martinsen’s understanding of the concept, as I see it. Spontaneous care, according to Martinsen, is “taking time to help another person that I meet by coincidence—be it a friend or a neighbor—and whom I see carrying a heavy burden” (Martinsen, 2003a, p. 74). However, taking time to help someone carrying a heavy burden does not necessarily imply the offer of “unconstrained help,” as Pettersen suggests. It is more important, according to Martinsen, to offer *unconditional care* to those who carry heavy burdens. However, unconditional care is not equivalent to unconstrained help. Unconditional care requires an immediate response to the suffering of the other, but it does not imply that we then devote ourselves fully to this person irrespective of the circumstances. Pettersen further suggests that “Samaritanism” treats those not “first in line” unfairly. However, how is it appropriate to speak of those “first in line” when it comes to people one meets by coincidence? Does this make any sense? Was the wounded man in the story of the Good Samaritan first in line? First in line among whom? Who came after him? Whether a more needy person would come after him, the Samaritan could not know, and such considerations should not influence the Samaritan’s immediate response to the needs of the patient, as I see it. However, considerations like these might well come into play after having dealt with the acute situation.

My interpretation of Samaritanism in medicine focuses on the ability to see and recognize patients who suffer, and to connect with them in the form of practical action. This is what Martinsen’s interpretation of the story of the Good Samaritan is about. It is not about offering unlimited, boundless care on behalf of the other who is suffering, but to *recognize* suffering when it is present, and to not pass by like the Priest and the Levite. Being able to

see what is at stake in situations like these represents, as I understand it, one of the main points in Martinsen's essay "Seeing with the Heart's Eye," and reflects a way to understand Samaritanism in health care today. If we take a medical setting as our point of departure, most of the patients a physician deals with during the day require no more than ordinary care. However, some patients "carry heavy burdens," and it may not always be possible to predict who these patients are in advance. Therefore, it is essential that health care personnel are able to recognize the need of these patients, and to act accordingly. These situations may appear unexpectedly and by coincidence, and require a spontaneous care response in order not to harm the other. This was the situation for the patient seeking a doctor because of earwax, where the consultation ended up in something quite different (see paper 1). This came unexpectedly for the doctor, and to handle the situation properly required a spontaneous act of care. It makes little sense to talk about distributive justice or a principle of "first come, first served" in this regard.

To sum up, in this part of the chapter I have tried to integrate perspectives of care in medicine by drawing on a theory of care from nursing. In working with Kari Martinsen's philosophy of caring I find her perspective relevant and applicable for medicine and medical ethics also. Her phenomenological analysis of care, in which she mainly relies on the phenomenological insights of Løgstrup, reveals an important aspect of human existence: that we as human beings are mutually interconnected and dependent. It offers as well important insights into the nature of care, emphasizing care as "concrete and present in a relationship" as well as "a movement away from ourselves and towards the other" (Martinsen, 1991, p. 11). We may thus find a "relational ontology" in the works of Martinsen. Furthermore, I have focused on the moral-epistemological implications of Martinsen's perspective, highlighting her emphasis on perception. This way of relating to others, and in our particular setting, of relating to patients, differs from the way we traditionally approach patients in medicine, and may be important to our ability to exercise care in the medical encounter, as well as in relation to our diagnostic and clinical abilities.

The third theoretical perspective I rely on in this thesis is the ethics of care, and in the following I will present some central theoretical insights of this tradition, relating them to the medical context. I will revisit some critical remarks, as well. First, however, I will further elaborate the concept of care.

2.3 An ethics of care

Within the field of care ethics, there is no clear-cut definition of the term “care”; nor is there any close agreement on what we should take its meaning to be (Held, 2006). Care may, for instance, be conceived of as an attitude, an ideal or value, a moral virtue, a way of acting and responding toward another, or as a relational competence and activity. Virginia Held considers care to be both value and practice: “The concept of care has the advantage of not losing sight of the work involved in caring for people and of not lending itself to the interpretation of morality as ideal but impractical to which advocates of the ethics of care often object. Care is both value and practice,” writes Held (2006, p. 9). “Care seems the most basic moral value. As a practice, we know that without care we cannot have anything else, since life requires it” (Held, 2006, p. 71). As we have seen, Kari Martinsen likewise highlights the practical dimension of care, and she points as well to an ethical dimension and a relational dimension of care (Martinsen, 2003a). According to Martinsen, care is concrete and practical, being present in a relationship: “Care is to be concrete and present in a relationship by our senses and our bodies. It is always to be in a movement away from ourselves and towards the other” (Martinsen, 1991, p. 11). This movement from ourselves toward the other is also reflected in Joan Tronto’s understanding of care: “First, care implies a reaching out to something other than the self” (Tronto, 1993, p. 102). She continues: “Second, care implicitly suggests that it will lead to some type of action” (Tronto, 1993, p. 102). Here too we see the practical aspect of care highlighted. This practical aspect is also important in the definition of care that Tronto, together with Berenice Fisher, formulates, suggesting that

caring be viewed as a *species activity that includes everything that we do to maintain, continue, and repair our “world” so that we can live in it as well as possible*. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web. (Tronto, 1993, p. 103)

The practical aspect of care is also evident in four phases of caring that Tronto and Fisher identify, first and foremost in the third phase of caring. Their first phase, *the caring about*, involves the recognition that care is necessary. The second phase, *the taking care of*, involves assuming some responsibility for the identified need and a determination of how to respond to it. The third phase, *the care-giving*, involves the direct meeting of needs for care,

that is, the direct action or actual physical work that is involved in the caring response (Tronto, 1993). The fourth and last phase of care Tronto and Fisher denote as *care-receiving*. This phase of caring recognizes that the object of care will respond to the care it receives and acknowledges the interrelation and interaction of the *homo patiens* and the *homo compatiens*.

In relation to medicine and health care, it may be useful to distinguish between “taking care of” and “caring for,” where “taking care of” refers to physicians’ delivery of technical care, and “caring for” includes an empathic or emotional engagement (Reich, 1995b; Marcum, 2008). Care in medicine, in the sense of caring for patients, is often recognized as a virtue (Peabody, 1927; Pellegrino & Thomasma, 1993), while at the same time it may be equated with the principle of beneficence (Beauchamp & Childress, 2009). In my analysis of care and care ethics in medicine I do not restrict myself to considering care as a virtue, but rather aim to include an understanding of care as a relational activity or competence, thus emphasizing the relational dimension of care.

2.3.1 The tradition

Carol Gilligan’s study *In a Different Voice* (Gilligan, 1982), often considered the origin of the development of care ethics, was originally a critique of her older colleague and teacher Lawrence Kohlberg’s stage theory of moral development (Kohlberg, 1981). When Kohlberg applied his stage theory to both girls and boys, it turned out that the girls’ solutions to the hypothetical moral dilemmas of the test differed from those of the boys. The girls tended to value responsiveness and connectedness with others, as well as the prevention of harm and maintenance of relationships, while the boys, on the other hand, tended to emphasize independence, justice, and abstract reasoning. The girls’ responses were given a lower score in the test; they seldom reached what Kohlberg denominated the highest level of moral reasoning, “the post-conventional stage,” where morality is characterized by an ability for moral abstraction and impartial reasoning based on universal ethical principles.

Consequently, these results led to the conclusion that the girls were less morally developed than boys, a conclusion that Gilligan refused to accept. She suspected instead that this result was due to an inherent sex-bias in Kohlberg’s theory, and started to trace this anomaly by doing her own research. Through studying girls’ moral reasoning, Gilligan hears another moral voice, where *caring for others in interpersonal relationships* is the main moral concern. Care and consideration for others expressed through care for the particular other

has a moral significance that is not captured by Kohlberg's stage theory and the theoretical tradition he represented. Based on her empirical findings, Gilligan articulates a moral perspective that challenges traditional moral psychology, which failed to include care as a part of moral deliberation. She names the two different perspectives she identifies a care perspective and a justice perspective. Gilligan writes:

To understand how the tension between responsibilities and rights sustains the dialectic of human development is to see the integrity of two disparate models of experience that are in the end connected. While an ethic of justice proceeds from the premise of equality—that everyone should be treated the same—an ethic of care rests on the premise of nonviolence—that no one should be hurt. (Gilligan, 1982, p. 174)

Thus, whereas the care perspective emphasizes care and consideration for others in a particular relationship, the justice perspective values impartiality and fairness, equality and reciprocity. However, even though Gilligan identifies a care perspective among the girls she interviews, she emphasizes that this gender difference in moral reasoning is not an absolute one. The differences in moral reasoning ought to be understood as a distinction between two *different modes* of moral reasoning. Thus, the care perspective represents a different moral voice, not necessarily a *woman's* voice. The care perspective is “neither biologically determined nor unique to women” (Gilligan cited in Pettersen, 2008, p. 9).

Even though Gilligan is considered the initiator of the ethics of care tradition, we may trace its beginnings even further back to the essay of philosopher Sara Ruddick, “Maternal Thinking” (Ruddick, 1980). As well as these works of Carol Gilligan and Sara Ruddick, Nel Noddings' (2003) phenomenological inquiry into what caring involves forms a part of the primary foundation of a feminist-based ethics of care. Eva Feder Kittay (1999), Virginia Held (2006), and Joan Tronto (1993) are all central theoreticians within the Anglo-American tradition of care ethics. We may also differentiate between different traditions of the ethics of care. Gilligan's Anglo-American tradition, connected to feminist ethics, may be differentiated from care ethics contributions related to theology (Gastmans, 1999; Vanlaere & Gastmans, 2011) and to phenomenological accounts such as the philosophy of Emmanuel Levinas (Nortvedt, 1996) and Knud E. Løgstrup (Martinsen, 2003b, 2003c, 2006). There are also sentimental versions of an ethics of care, relying exclusively on the human capacity for empathy (Slote, 2007).

Whereas care and care ethics occupy a central place in much of the literature on nursing ethics (Leininger, 1980, 1988; Bradshaw, 1996; Benner, 1997; Nortvedt, 2008b; Gallagher, 2012), it is still situated at the margins of much of the ethical thinking in medicine, where the principle-based approach of Tom L. Beauchamp and James F. Childress still dominate. Beauchamp and Childress's work *Principles of Biomedical Ethics* (2009), centered around the four principles of autonomy, justice, beneficence, and non-maleficence, is considered among the most influential works in medical ethics, and has provided the conception of medical ethics that currently dominates the practical context in ethics committees, clinical case-discussions, and ethics courses (ten Have, 2005; Kohlen, 2009).

2.3.2 *Central insights*

The main concern of an ethics of care is the harm caused in relationships owing to a lack of care (Gilligan, 1982; Pettersen, 2008). This is a concern that is not treated sufficiently in dominant ethical theories, even though empirical research shows that a lack of relational care and consideration may cause pain, sorrow, and suffering for the people involved (Pettersen, 2006).³⁰ Care ethics provides us with a novel reading of human relations, where caring in relationships is considered to be of moral importance. That is, how we meet the other and how we take care of the other in a relationship become ethically significant, because by not caring, we may hurt the other. As a consequence, an ethics of care is more concerned about the dangers of abandonment than the dangers of interference (Quill & Cassel, 1995; Verkerk, 2001), a concern that is reflected in the injunction "not to turn away from someone in need" (Gilligan, 1995). This injunction serves to highlight the focus of care ethics: namely, relational harm. That is, instead of focusing on the danger of interference in terms of violating a person's autonomy, an ethics of care puts the emphasis on the harm caused by abandonment and a lack of care in a relationship.

Further, it is characteristic of an ethics of care to view persons as relational and as interdependent. Persons are conceptualized as "deeply affected by, and involved in, relations with others (Held, 2006, p. 46). Such an understanding of the moral agent as a *related self* is a specific normative feature of an ethics of care:

³⁰ Here Pettersen refers to the works of Gilligan (1982, 1996); Gilligan, Lyons & Hanmer (1990); Taylor, Gilligan and Sullivan (1995); Opjordsmoen, Vaglum & Bloch Thoresen (2005).

One characteristic feature of the ethics of care, and also a reason for its swift growth and applicability, is its relational ontology. The ethics of care depicts the moral agent not primarily in terms of independence, equality of power and influence, enjoying almost unrestricted freedom to enter and dissolve contracts. Rather, it conceives agents as mutually interconnected, vulnerable and dependent, often in asymmetric ways. (Pettersen, 2011a, p. 52)

Tove Pettersen finds such an ontological starting point in the works of Gilligan and in her understanding of interdependence as a common human experience. No child can survive without being in a relationship, and as children grow up, they continue to exist in a web of relationships (Gilligan, 1982; Pettersen, 2008). By outlining the moral self as a related self, an ethics of care also relies on the critique of feminist philosophers of the model of the moral self inherent in universalistic moral theories (Baier, 1986; Benhabib, 1992; Mackenzie & Stoljar, 2000; Donchin, 2001). Seyla Benhabib, for instance, points to how contractarian theories from Hobbes to Rawls inherit a conception of the moral self as “disembedded” and “disembodied” (Benhabib, 1992), a model emanating from the metaphor of the state of nature, the message of which is that “in the beginning man was alone” (Benhabib, 1992, p. 156). Benhabib cites Hobbes’s understanding of men as “mushrooms, come to full maturity without any kind of engagement to each other” (Hobbes cited in Benhabib, 1992, p. 156). Such an understanding of the self frees the ego from its most natural and basic bonds of dependency—that we have all been borne of and dependent upon another human being. From such an atomistic understanding of the moral self, social interactions are framed in terms of a social contract, where individuals are to be considered mutually disinterested.

We see from this how the different ways of conceiving of the self influence our perception of human relationships. Where a contractarian sees social interactions in terms of a contract of indifferent equals, a care ethicist conceives of the relationship as a relation characterized by vulnerability, interdependency, and connectedness. To put it in the words of Gilligan, a separate self tends to regard all relationships as an interaction between separate and equal autonomous individuals. The related self tends to perceive all relationships as an interaction between connected and interdependent persons (Gilligan, 1982; Pettersen, 2008). A consequence of the relational ontology of an ethics of care is that it accentuates different features than do other ethical theories, as, for instance, featuring the harm caused by lack of

care, as well as highlighting the possibility of agents' vulnerability and dependency. Within the analytical concepts and categories of an ethics of care, what is considered relevant within a care perspective is not identical with what is given emphasis in other theories.

The moral epistemology of an ethics of care stresses sensitivity to the different relevant considerations in particular contexts, and it promotes a dialogue that corrects and enriches the perspective of any one individual (Held, 2006). It includes "taking experiences into account, exercising self-reflections and sensitive judgments where contextual differences are attended to" (Pettersen, 2011a, p. 55). Joan Tronto points to the importance of attentiveness in an ethics of care: "Since care requires the recognition of a need and that there is a need that be cared about, the first moral aspect of caring is attentiveness" (Tronto, 1993, p. 127). This kind of attention, or moral perception, constitutes an important epistemological aspect of care and an ethics of care, and is discussed by different care ethicists, among them Kari Martinsen, who highlights the importance of seeing with a perceiving eye (Martinsen, 2006). Likewise, Per Nortvedt explicates the concept of sensibility, defining it as "receptiveness for and a sensitive understanding of the subjective situation of other people" (Nortvedt & Grimen, 2004, p. 37).

2.3.3 Critical remarks

Many cautions have been raised about an ethics of care, and since its beginnings in the 1980s it has been subject to various criticism. By reflecting upon and emphasizing the work of caretaking that women traditionally have been confined to, we may ask whether the ethics of care contributes to prolonging such an inequality (Held, 2006). We may also ask, like Virginia Held, whether an ethics of care mistakes "a merely historical fact—that women have done most of this labor—for a claim about women's outlook on moral issues" (Held, 2006, pp. 61–62). There may also be a risk that the ethics of care draws attention away from other oppressive social structures, by focusing on particular others in particular relationships; that we as care ethicists are "fiddling while Rome burns" (Purdy, 2001). Does care ethics locate its work in an ivory tower, tending to shy away from the most morally urgent issues? For instance, in health care, showing that patients need more human contact and care seems rather meaningless at a time when nursing staffs have been cut to the bone because of broader political agendas (Purdy, 2001). This worry, about focusing on the dyad of the doctor or nurse and patient without taking into account the overall political and organizational structure and the setting within which this dyad functions, is a timely one,

and also poses a challenge to my perspective in this thesis, focusing as it does on the basic dyadic relation in medical practice. Does it matter how we *see* the patient, if there is no time to care? However, as I see it, this critique affects our scope of investigation as medical ethicists more than it affects the overall relevance of an ethics of care, since an ethics of care focuses not only on dyadic care and proximity. It aims to reach beyond the dual unit of caretaker and caregiver, thus encompassing both political and global issues (Tronto, 1993, 2010; Held, 2002; Cockburn, 2005; Holland, 2010; Mahon & Robinson, 2011; Robinson, 2011; Skirbekk & Nortvedt, 2011; Nordhaug & Nortvedt, 2011).

Some critics find the notion of care itself problematic (Allmark, 1995; Holm, 1997; Curzer, 2002). Peter Allmark argues in his article “Can There be an Ethics of Care?” that the term “care” has no meaning; that it has no normative or descriptive content, but merely denotes what is important to us: “Caring is not good in itself, but only when it is for the right things and expressed in the right way” (Allmark, 1995, p. 19), and draws the further conclusion that “‘Caring’ ethics assumes wrongly that caring is good, thus it can tell us neither what constitutes those right things, nor what constitutes the right way” (Allmark, 1995, p. 19). In her reply to Allmark, Ann Bradshaw argues that by cutting off the concept from its roots, as Allmark does in his article, and analyzing it separately from the long tradition of care in nursing, “the very concept of ‘care’ cut off from its roots becomes a meaningless term without either normative or descriptive content” (Bradshaw, 1996, p. 8). Hence, what Allmark shows in his analysis, Bradshaw argues, is that care shorn of its original meaning and context becomes meaningless. By drawing such an inference Allmark is not right in assuming that there can be no ethics of care, Bradshaw argues, pointing to the moral tradition of care within nursing, stretching back through the ages: “The moral basis and thus the content and direction of care have been our nursing heritage, a foundational assumption, however little articulated” (Bradshaw, 1996, pp. 11–12). Even though both Allmark and Bradshaw are teachers of nurses, and the reply of Bradshaw refers specifically to the tradition of care within nursing, this exchange is also representative of a similar incongruence between critics approaching the concept of care with an analytical approach (Holm, 1997; Curzer, 2002), isolating it from the ethical life of caring practices, and thereby also from its focus on experiences and relationships traditionally associated with women and their care work.

Another frequent criticism of an ethics of care is that this position has nothing to say about certain forms of injustice (Nelson, 1992). This worry may be representative of the liberal critique of care ethics, which assumes that there is a conflict between care and justice, and that justice must always have priority (Held, 2006). Care ethicists deny such a divide between care and justice, calling it a “false dichotomy” (Tronto, 1993). Instead they argue for an integration of justice and care orientations, retaining their respective strengths through rehabilitated notions of the terms of both justice and care (Carse, 1991).

A further worry about care ethics, one related to the question discussed above, is that it offers little guidance with regard to issues like prioritization and fairness in health care systems (Nordhaug & Nortvedt, 2011; Skirbekk & Nortvedt, 2011). Will physicians be inclined to favor their patients over other physicians’ patients or other needs of the community? Nordhaug and Nortvedt discuss what they see as an ethical conflict between different conceptions of moral responsibility related to care and justice. They question the conflicting normative claims of partiality, providing for the caring needs of the particular patient, and the impartial claims of treating all patients with a relevant need equally (Nordhaug & Nortvedt, 2011). Discussing this problem within a health care setting, they analyze how partial concerns might be balanced against claims of distributive justice within the framework of the formal principle of justice, and they conclude that this problem cannot be resolved on an individual and clinical level, but needs to be addressed by organizational structures and priority decisions at a macro level. However, as I see it, even though the authors acknowledge the importance of partiality and particularity in relation to care, they tend to discuss it from the premise of a theory of justice, instead of also trying to discuss dilemmas of distribution of health care resources starting from the premise of an ethics of care. Instead of discussing care in relation to justice, an explorative discussion of the potential of care to deal with questions of distribution would have contributed to challenge the perspective of care in its own right, instead of opposing it to the idea of justice. According to Held, it is a misunderstanding that an ethics of care is particularistic in the sense that it is limited to the narrow contexts of caring relationships: “The care that is valued by the ethics of care can—and to be justifiable must—include caring for distant others in an interdependent world, and caring that the rights of all are respected and their needs met” (Held, 2006, p. 66). An interesting question in this respect would be in what way physicians and nurses may care for distant others in an interdependent world.

Linked to this critique of an ethics of care is the question of its relation to moral principles (Rudnick, 2001). Some protagonists of care, such as Noddings, are critical of principles, and principlism in ethics is usually seen as in opposition to care ethics (Noddings, 2003). However, this is not a universal view, as there are scholars who also aim to contribute to the development of principles or ideas within an ethics of care. In her earlier works Kari Martinsen discusses whether there is an overall principle or model for an ethics of care that prevents it from turning into relativism (Martinsen, 2003a). Drawing on the works of the Danish philosopher Uffe Juul-Jensen, she recognizes such a principle or idea, one that she calls “the principle of responsibility for the weak” (Martinsen, 2003a):

Through historical-empirical studies of human actions arguments are provided that *the principle of responsibility for the weak* is such an overall or comprehensive value, principle or ideal. It applies for different cultures at different times. The principle can not be proved, but it can be justified by historical studies. (Martinsen, 2003a, p. 15)³¹

Martinsen sees in this principle that we all are responsible for each other: “We may all come into a situation where we need help from others. Therefore we should act in such a way that everyone gets a similar opportunity to live the best life they are capable of” (Martinsen, 2003a, p. 15).³² In her further discussion of this principle, Martinsen refers to a discussion between Nel Noddings and Jean Grimshaw regarding principles in ethics. While Noddings rejects principles (Noddings, 2003), Grimshaw recognizes the importance of principles for moral reflection and moral action (Grimshaw, 1986), and she formulates a principle that involves actions of care: “Consider whether your behavior will stand in the way of maintaining care and relationships” (Grimshaw, 1986, p. 209). In her elaboration of Gilligan’s ethics of care, Tove Pettersen recognizes *the idea of not hurting* as having primacy, encompassing how we meet the other, and how we take care of the other in a relationship in order not to hurt the other (Pettersen, 2008). This idea serves to highlight and preserve the two normative core values of care ethics: the condemnation of exploitation and

³¹ “Gjennom historisk-empiriske studier av menneskelige handlinger gis det argumenter for at *prinsippet om ansvaret for svake* er et slikt overordnet eller omfattende verdiprinsipp eller forbilde. Det gjelder for ulike kulturer til ulike tider. Prinsippet kan ikke bevises, men det kan begrunnes ut fra historiske studier” (Martinsen 2003a, p. 15).

³² “Vi kan alle komme i den situasjon at vi vil komme til å ha bruk for hjelp fra andre. Vi bør derfor handle slik at alle kan få samme muligheter til å leve det beste liv de er i stand til” (Martinsen, 2003a, p. 15).

harm and the commitment to human flourishing (Pettersen, 2011a). Pettersen formulates this as a principle related to the principle of non-maleficence, but it is expanded to also include active beneficent behavior, that is, caring behavior (Pettersen, 2008).

I will not go into a further discussion of care ethics and principles here. But by highlighting these attempts to formulate care ethical ideas or principles, I suggest that there may be an alternative to total contextual sensitivity on the one hand and an unconditional principlism on the other, which includes “a sincere readiness to recognize that principles as well as judgments and intuitions can be revised” (Pettersen, 2008, p. 75). This standpoint I share with Pettersen, and by analyzing care and an ethics of care in relation to medicine and medical ethics, my aim is not to entirely reject principlism in medical ethics in favor of care, but rather to constructively inform the principles as they are understood today.

To this point I have expanded upon the three theoretical perspectives that I rely upon in this thesis, in order to provide a more thorough account than is provided in each of the three articles. Even though the theoretical background is somewhat diverse, reaching from an anthropological tradition within the philosophy of medicine, via a contribution from philosophy of nursing and nursing ethics, to the tradition of an ethics of care influenced by feminist philosophy and feminist ethics, the thesis nonetheless follows an underlying analytical thread, one related to our understanding of the patient, the health care professional (physician) and the relation between them. In the following chapter I will present the content of my three published papers relevant to the dissertation, and try to reassemble the insights from each of the papers in relation to the objectives of this thesis.

3. Synopsis of the papers

The present PhD dissertation is built around three research papers published in peer reviewed journals. I am the sole author of two papers (papers 1 and 2), and the first author of paper 3. In this section I present the three papers in relation to each other and to my research questions. The main question of the section is how the papers address one or more of the objectives of the thesis. As is conventional, the papers have been numbered according to the date of their final publication, but in accordance with the structure of the thesis, paper

3, where I introduce the medical anthropology of von Weizsäcker, is presented first. Although this paper was published last, it nonetheless represents the material starting point of the thesis. It was this work on ill-being from which my further interest in care and care ethics evolved, eventuating in the two other publications.

3.1 Paper 3: Illness as a condition of our existence in the world: On illness and pathic existence (2012)

This paper evolves from my engagement with the writings of Viktor von Weizsäcker. Starting from von Weizsäcker's plea for a "metaphysics" of the ill, the paper addresses the first intermediate objective of the thesis: To illuminate what it means to be perceived as and to exist in the world as an ill person. His work represents a theoretical perspective on ill-being; in von Weizsäcker's words, it develops and makes visible a "pathosophy" for medicine.

In the paper I outline von Weizsäcker's idea of illness as "a way of being human," which involves analyzing his view of the pathic subject and of pathic existence. Central to this project is his use of what he calls the pathic categories: the modal verbs can ("können"), will ("wollen"), may ("dürfen"), must ("müssen"), and shall ("sollen"). By applying these pathic categories, these modes of ill-being, to the case story of Nicole, a woman suffering from lymphatic cancer, I illustrate how these categories illuminate important aspects of ill-being. I describe how the situation of not being able to, of "nicht-können," is expressed in Nicole's inability to do simple, everyday tasks because of the adverse effects of her cancer treatment. The situation of wanting to do something that is in theory possible, but not realizable because of the pressing realities of the disease or its treatment ("wollen"), points to something essential in the experience of illness. I also invoke Virginia Woolf's self-description in a similar situation. She expressed a desire ("wollen") to write, but was unable to do so during periods of severe illness. I show how the category of must ("müssen") is relevant to the ill-being of a person enduring a disease, like Nicole, undergoing difficult treatment regimes, or to persons living with a chronic disease, or to those who have to face death. The mode of "dürfen," on the other hand, reflects the element common to the therapeutic context of being given permission or being-allowed-to as a patient, while the

mode of “sollen” reflects the resistance that these imperatives may generate in one who is ill.

For von Weizsäcker, human ailment is central for our understanding of human existence as pathic existence. Accepting his claim that illness too is “a way of being human,” a greater understanding of the pathic not only illuminates important aspects of the illness experience, but also points to central features of human existence as such. As I interpret von Weizsäcker, illness may be said to play a paradigmatic role in calling attention to an often ignored or neglected part of what it is to be human.

This is a claim that has some interesting epistemic and ethical implications, both with regard to a theoretical understanding of ill-being, and for the normative handling of it. In the last part of the paper I address these implications, and discuss how von Weizsäcker’s position differs from other contributions in the field, especially some phenomenological literature that also deals with the experience of illness. I refer in particular to the works of Fredrik Svenaeus, Kay Toombs, Drew Leder, and Havi Carel, all of whom tend to understand illness as something foreign and unwelcome in our lives, that is, as a “gradual process of alienation” and “unhomelikeness” (Svenaeus, 2000, 2009), as a “disruption” (Toombs, 1988), as a “dys-appearance” (Leder, 1990) or as a “dis-ability” (Carel, 2008). These perspectives differ from von Weizsäcker’s understanding of the human being as a suffering creature. That is, suffering and illness are not something that we can get away from. They are always looking for new paths, and as such are constitutive of our basic way of existing. In the last part of the paper I discuss this basic way of understanding human life in the context of the prevailing drive in modern medicine of constantly striving to get away from ailment, to get rid of it—an attitude in medicine that von Weizsäcker denotes as a “weg damit” attitude of physicians. In the concluding part I suggest that acknowledging “illness as a way of being human” may address an important normative anomaly in modern health care: its failure to accept mortality.

3.2 Paper 1: Care for nurses only? Medicine and the perceiving eye (2011)

This paper is the starting point of my exploration of care in medicine, and addresses the second intermediate objective of this thesis: To explore how the conceptual vocabulary of an ethics of care might contribute to illuminating ill-being and the ill person/medical helper

relation. Here I take the works of Kari Martinsen as my point of departure, discussing her philosophy of caring in relation to medicine. Even though Martinsen is an influential theoretician and philosopher within the field of nursing in Nordic countries, her works have rarely been referred to in the fields of medicine and medical ethics. This made me curious: What might her perspective contribute to medicine and medical ethics?

In the paper I focus mainly on the moral-epistemological implications of her work, her analysis of the different clinical gazes in health care. I discuss Martinsen's distinction between "the perceiving eye" and "the recording eye," and relate these two to the way we see in medicine, concluding that the main gaze of medicine is what she terms a recording gaze. This way of seeing patients, I argue, excludes "seeing emotions" in our encounter with the patient, and may lead to an objectification of the other. To illustrate an important ethical side-effect of the recording eye in medicine I make use of a personal account written by author Kristin Ribe, a patient suffering from a psychiatric condition that involved self-mutilation. The perceiving eye, I argue, may contribute to protecting patient integrity, and may contribute as well to strengthening the ability of the patient to face life with courage. I aim too in this paper to demonstrate the epistemological relevance of care in the clinical encounter. By being more aware of our own "seeing emotions" in meeting with patients, we may be able to capture important information regarding the patient's clinical situation. Thus, a perceiving eye may also contribute to refining our clinical abilities.

For a physician to cross the border to nursing philosophy and care ethics may not be uncontroversial. In the last part of the paper I discuss possible drawbacks of highlighting a care perspective in medicine, discussing whether care may inhibit medical practice and lead to difficulties for the physician, hampering our ability to subject patients to necessary therapeutic pains, or with regard to breaking bad news. I address the worry that certain well-established conventions relating to partiality, favoritism, and injustice may fall outside the reach of medicine if an ethics of care were more fully integrated into medical practice. Finally, I discuss the presumption that an increased focus on care and caring relationships in medicine would lead to more burnout among physicians. In conclusion, I argue that medicine needs to expand its way of seeing patients in the clinical setting, and to be more open to involving the physician's own affectedness in the clinical evaluation of patients.

3.3 Paper 2: Harm in the absence of care: toward a medical ethics that cares (2011)

This paper also relates to the second intermediate objective of the dissertation, exploring how the conceptual vocabulary of an ethics of care might contribute to illuminating ill-being and the relation between the ill person and the medical helper. Whereas paper 2 focuses on the clinician's way of seeing, challenging the traditional way of seeing in medicine, this paper focuses on inherent assumptions about the nature of the moral self in medicine and medical ethics. Paper 2 deals with the moral/epistemological features of an ethics of care in medicine, while paper 3 deals with the moral/ontological features of an ethics of care. In my discussion I draw, among others, on the works of Carol Gilligan, Tove Pettersen, and Virginia Held, all representatives of the Anglo-American tradition of care ethics, a tradition that stands in contrast to the care tradition deriving from nursing and phenomenology, of which Martinsen is a representative.

I focus attention on an ethical challenge that is seldom discussed in medical ethics: the harm to which patients may be exposed due to a lack of care in the clinical encounter. I address this challenge of "harm in the absence of care" from the vantage point of Gilligan's admonition "not to turn away from someone in need." I focus on the ontological features of an ethics of care, taking a relational ontology as my point of departure. An ethics of care depicts the moral agent not primarily in terms of independence, equality of power and influence, but rather conceives of agents as mutually interconnected, vulnerable, and interdependent. I then discuss this important dimension of an ethics of care in relation to what we may see as the modern ideal of detachment and non-interference in medicine, and I point to how this model of the moral agent as detached and independent may be traced in the dominant discourse on empathy and autonomy in medicine and medical ethics, as well as in the prevailing medical understanding of care as a principle of beneficence and a virtue of compassion. I then argue that this ideal of detachment and separatedness may present an obstacle to making sense of care in medicine, and that medicine, in order to avoid situations in which patients are "harmed in the absence of care," needs to acknowledge the relational reality of care, and to work for an understanding of physicians and patients as related selves.

3.4 Reassembling the three research papers

In what way do these three papers contribute to the overarching objectives of this thesis? In the previous paragraphs I have explained how the three papers relate to the first two intermediate objectives. The third intermediate objective, making visible some consequences of introducing the set of concepts and perspectives developed in the thesis for today's medical practice, will be addressed in this last part of the thesis.

My experience with the Bosnian patient induced in me a wish to expand the theoretical framework dealing with patients in medicine. I started to look for a more “holistic view,” which led me to return to the basic phenomenon as formulated by von Weizsäcker—a need that manifests itself as a plea for help—and thence to an exploration of both the patient as pathic subject and the physician as carer.

An important result of this encounter is my claim that medicine needs to cultivate another way of seeing patients, to develop a perceiving eye, in addition to its usual way of observing and clinically evaluating patients. As I see it, von Weizsäcker's quest for a “metaphysics” of the ill represents both an *epistemological* plea—the need for a more comprehensive theory of the patient that includes the existential aspects of being ill—and an *ethical* plea—that physicians be able to capture the patient's state of being in need. In the words of von Weizsäcker, “the real essence of ill-being is a *need* that manifests itself as a plea for help” (von Weizsäcker, 1987a, p. 13).³³ It is clear that von Weizsäcker also aims to operate within the “perceiving range of life.” To be able to grasp the metaphysics of the ill, we must not only see the patient with a recording eye, studying the patient's tissue or cells in a microscope, or observing him or her with a purely clinical gaze; we must also be able to capture his or her emotional needs, and see the patient with a perceiving eye. Here we see a family resemblance between von Weizsäcker's and Kari Martinsen's understanding of care as being able “to see and express the [patient's] appeal for help” (Martinsen, 1993, p. 9). Although von Weizsäcker does not write explicitly about care, he does point to an important prerequisite for care in clinical practice, the clinician's ability to see (and hear) not only the patient's physical needs, but also more experiential and existential needs. This ability to capture the patient's state of being in need also comports well with Gilligan's ethical idea of

³³ “Das wirkliche Wesen des Krankseins ist eine *Not* und äussert sich als eine Bitte um Hilfe” (von Weizsäcker, 1987a, p. 13).

not turn[ing] away from someone in need. By seeing the patient with only a recording eye, focusing on his or her physical attributes and expressions in order to make a proper diagnosis, we may come to turn away from this patient in need. The emotional and mental harm that a lack of care in the doctor-patient relationship may cause to patients represents an ethical challenge that is seldom discussed in medicine.

I argue that medicine's ontological point of departure may have an impact on how physicians perceive and interpret their relationship to patients, and how they handle situations in clinical practice. Martinsen's phenomenological analysis of care points to how we are mutually interconnected and interdependent as human beings, and how this mutual relatedness provides important insights in relation to the nature of care, highlighting care in the sense of being present in a relationship as "a movement away from ourselves and towards the other" (Martinsen, 1991, p. 11). We may thus trace a "relational ontology" in the work of Martinsen, which we also find in the tradition of an ethics of care. That is, the understanding of the moral agent as a related self represents a specific normative feature of an ethics of care, which, together with the moral injunction of *not turning away from someone in need*, serves to highlight the focus of care ethics on relational harm.

From this I argue that a greater emphasis on care in the ethical discourse of medicine may deepen our understanding of the interaction between physician and patient. Seriously engaging with the moral epistemological and moral ontological implications of an ethics of care within a medical context, be it the Nordic tradition of an ethics of care in nursing represented by Martinsen or the Anglo-American tradition initiated by Gilligan, contributes to improving the interactions between physician and patient by challenging medicine's way of perceiving patients and highlighting human interdependency and connectedness.

By questioning the underlying idea of the moral self in medicine and medical ethics, as well as by elaborating on the pathic nature of human existence, the papers also take part in the anthropological activity of clarifying in what way the images of persons may inflect our perception of ethical challenges in clinical practice: The papers illustrate how the understanding of the self may influence how people understand and act in the world—including how physicians both perceive and interpret their relationships to patients and how they deal with human ailment in medicine. I will further enlarge on this theme in the following chapter.

4. Lessons of care and pathosophy

So, what are further implications of the work to this point? What insights have emerged, and what additional areas need to be addressed? If there are critical objections, they need to be addressed, and there are as well interesting tracks for further investigation. In order to come to terms with the main objective of this thesis, to develop theoretical insight in medicine in order to contribute to a better normative understanding of what care for the ill person entails, I suggest we need to concentrate on the following four areas:

1. Understanding illness as a “way of being human”: What may that imply for medicine and medical ethics?
2. The way of seeing in medicine.
3. The model of the moral agent in medicine and medical ethics.
4. The prevailing understanding of care in medicine.

In this chapter I will follow up on these four areas, with the aim of illuminating the third intermediate objective of this thesis: making visible some consequences of the set of concepts and perspectives developed here for today’s medical practice. Despite the ancient call to physicians to be “always comforting,” it is not uncontroversial to argue in favor of implementing care and care ethics to a greater degree in medicine. Some might find it inappropriate, conceiving of care in medicine as an “oxymoron” (Mackenzie, 1997), or claiming it to be potentially dangerous for the physician’s own health (Sweet, 2003). Others might find it unnecessary, arguing that medicine already deals with these aspects of care, but under different descriptions (Brekke, 1998; Short, 1998). A further aim of this chapter is therefore to clarify and discuss some of the possible reasons for this ambivalence related to care in medicine. Finally, I reflect on some of the didactic challenges of facilitating care in medicine, and indicate some areas for further research.

4.1 Lessons of pathosophy (and the implications for care)

I will now look more closely at some of the normative implications of the pathosophic project of von Weizsäcker, relating it to the field of care. Even though von Weizsäcker did

not thematize care, some of the underlying assumptions in his project may be concordant with some of the assumptions of care ethics.³⁴

In paper 3 I aim to advance an illness perspective in medicine. Conceiving of illness as “a way of being human,” I elaborate on ill-being in terms of the pathic modes of will, shall, can, must, and may. I point out that it may be important for the medical helper to hold such a perspective on the ill person in order to be able to deal with the “metaphysics” of the ill. That is, being curious about the patient’s ill-being as a medical helper may contribute to expanding our understanding of the patient, which makes us better able to capture the patient’s needs. For instance, if my fellow students and I had been encouraged to also reflect about the patient’s ill-being in meeting with the Bosnian patient, we may have come to treat him differently than just leaving the room after finishing his physical examination.

Being able to hold an illness perspective in medicine not only requires of us that we be able to *reflect* about ill-being, but also that we be able to *see* the patient differently than just by the process of recording. An illness perspective also requires a perceiving gaze. That is, to capture ill-being we must also be able to see, or in the words of von Weizsäcker, *hear*, the patient’s need. In this way the perspectives of von Weizsäcker and Martinsen unite in the basic phenomenon of medical practice. By pointing to the importance of hearing the patient’s “plea for help,” von Weizsäcker expresses an important insight: that an illness perspective that aims to embrace the metaphysics of the ill also requires a perceiving eye. That is, this way of seeing patients in medicine is important for capturing the patient’s ill-being, and it represents an important prerequisite for care.

4.1.1 *Weg damit (away with it)*

Elaborating on the pathic categories, von Weizsäcker points to the resistance that the imperative of “sollen” may generate in the one who is ill. He cites examples of “obstinate”

³⁴ In contrast, the concept of care in relation to German medicine during the Nazi era is characterized by the ideals and practice of “Vorsorge,” understood as “preventive care that respects emerging needs of the entire society” (Reich, 2001, p. 64). That approach justified, for instance, a massive execution of children as part of the Nazi euthanasia program. Warren T. Reich shows how there was a shift in the medical ethos in Germany prior to and during the Nazi era, where commitments to care of individual sick persons (“Fürsorge”) had to give way to a preventive care that respected emerging needs of the entire society (“Vorsorge”) (Reich, 2001). Reich thus formulates the development of the “National Socialist ethic of care” in the following way: “They took the *Sorge* (the deeper, worried care) out of the *Fürsorge* (caring for) that is oriented to the individual patient and relocated it to a dangerous extent in *Vorsorge* (global caring for a holistic need); i.e., a preventive care in the interests of the German *Volk*” (Reich, 2001, p. 69).

patients, who do not do as they are told in order to get well, whether undergoing an operation, stopping smoking, or staying in bed (von Weizsäcker, 1967). This protest or resistance may be directed toward the state of being commanded, “you should,” but it may as well be directed toward the demand on the part of the medical establishment that we should constantly strive to be healthy and to get well. Thus, within medicine “sollen” has special importance because healthiness is regarded as the “Sollzustand” (the condition that shall be) and disease is regarded as the opposite (Fichter, 2007).

Von Weizsäcker raises a criticism against the attitude in medicine and health care that “a human being shall *be* healthy, not ill” (von Weizsäcker, 1967, p. 80).³⁵ However, “there is no naïve, vulgar reason to assume that ‘shall’ in Dasein’s compass needle is always pointing toward that which is good, beautiful, truthful, healthy, and complete” (von Weizsäcker, 1967, p. 82).³⁶ This criticism is in accordance with his pathosophical project, emphasizing the precedence of disease over health, as earlier outlined. He further points to the tendency of medicine to always approach disease with an “away with it” attitude (“weg damit”) (von Weizsäcker, 1988b, p. 318). According to von Weizsäcker, such an inherent “weg damit” attitude to human ailment in medicine may also be interpreted as an expression of a general attitude toward life that is characterized by a continuous striving for happiness (von Weizsäcker, 1988b): Away with that which is uncomfortable, “weg damit”! We may relate this attitude of “weg damit” to the imperatives in medicine of possibility and action (Hofmann, 2002b).

The *imperative of possibility* refers to an attitude among health care practitioners that all “that which is possible to do has to be done” and that “we have to try (everything possible)” (Hofmann, 2002b, p. 676). Since we may sustain life by advanced treatment, we ought to provide it. Some authors have said of this tendency among physicians to try everything possible that they are “held hostage” by the possibilities provided by advances in technology (Muraskas, Marshall, Tomich, et al., 1999, cited in Hofmann, 2002b, p. 676). Hofmann also points to an *imperative of action*. This imperative consists of the attitude that passivity is a vice. We often encounter this imperative in the form: “Don’t just stand there—

³⁵ “Ein Mensch soll gesund, er soll nicht krank *sein*” (von Weizsäcker, 1967, p. 80).

³⁶ “Dass im übrigen die Kompassnadel des Soll im Dasein immer auf Gutes, Schönes, Wahres, Gesundes und Vollkommenes, also auf eine Art Eubiosie gerichtet sei, dies naiv-vulgär anzunehmen besteht kein Grund” (von Weizsäcker, 1967, p. 82).

do something!” or “We do not want to be accused of not having tried, do we?” There seems to be an imperative toward active response, and technology has become the paradigm of effective action. In particular, there is a wish to respond positively in situations where patients are critically ill, have distressing symptoms, or have a dreaded diagnosis. Human ailment is something to be acted on and preferably gotten rid of, and even though the patient is almost dying, the drive to “do something” may be stronger than the more sensible course of not doing.

This drive for active doing in order to come to terms with ailment contrasts with von Weizsäcker’s emphasis on realizing the pathic nature of our everyday lives. Operating within the context of medical anthropology, he points to how illness and ill-being may tell us something about human existence as such, whether we are ill or well. Such a view, I think, may positively influence our attitudes toward ailment in general and toward the ill human being in particular. We may come to accept ailments as a part of our lives to a greater extent than is the case today—instead of constantly trying to get away from ailment, to get rid of it—and by so doing we might also become better able to deal with it.

If we further relate this perspective to the field of medical ethics it may illuminate an important normative anomaly in modern health care: its failure to accept mortality. We may trace this failure in the drive for action and intervention in modern medicine, and we may find it as well in ethical dilemmas concerning the termination of life-prolonging treatments of terminally ill patients. Studies indicate that a substantial percentage of cancer care spending, for instance, occurs in the last weeks and months of life, and that in a large percentage of cases, such care is not only futile, but might have been contrary to the goals and preferences of many patients and families if they had been adequately informed of their options (Sullivan et al., 2011). This reflects the enduring potency of the “weg damit” attitude in medicine, as I see it, where physicians, instead of realizing the mortal reality of a deadly disease in its final stages, still try to deal with it, “weg damit,” in a more or less hopeless way.

4.1.2 Ja, aber nicht so (yes, but not like this)

In contrast to the attitude of “weg damit,” von Weizsäcker encourages his students to adopt an attitude of “yes, but not like this.” “Until recently the attitude to disease has been: ‘Weg damit.’ However, I tell [the students]: Your attitude to disease should be: ‘Yes, but not like

this” (von Weizsäcker, 1988b, pp. 318–319).³⁷ Such an attitude implies an element of reserve, as noted by Kari Martinsen, and holds the potential for caring. That is, in the “yes” there is an acceptance of the whole patient: *Yes* (we see you and recognize you), *but not like this* (while at the same time we want to help you to achieve recovery and healing). Von Weizsäcker thus pursues a medicine that aims to house and contain the diseased and pathological, while at the same time it aims to heal and soothe. This point reflects an important normative implication of von Weizsäcker’s pathosophy: By accepting ailment in the medical field to a greater extent, we may encourage a greater emphasis on care and consideration for the patient, instead of constantly focusing on curing the disease alone.

This negative effect of a “weg damit” attitude in medicine is clearly illustrated in the movie *Wit*, where we meet Dr. Vivian Bearing, a professor of Old English literature, who has been diagnosed with metastatic ovarian cancer.³⁸ The movie contains several scenes dealing with interactions between the patient, Vivian, and two physicians, Dr. Posner and Dr. Kelekian. There is an element of caricature in the portrayal of the physicians, but many of the scenes nevertheless sharply illuminate some of the points that I am trying to make in this thesis, and so provide a vivid and accessible illustration of the tendency I wish to address.³⁹ Vivian Bearing is undergoing a very demanding treatment. However, as a consequence of the physicians’ persistent encouragement to “keep pushing fluids”—that is, to continue receiving the high dosages of cytostatics they prescribe—Vivian is not treated as an “end” in her own right, but only a “means” to fulfill the physicians’ prescriptions. For her, there is little time for reflection on the disease and its possible outcome, and she gets little opportunity to prepare for death under her doctors’ reiterated urgings to go for “the full dose.”

The physicians do not manage to relate to her ill-being; they do not relate to the way she faces the necessities of her disease (“müssen”) nor to how she may live through the modes of “können” or “nicht können” as she suffers from nausea and pain, loss of appetite, and

³⁷ “Bisher war die Einstellung zum Krankhaften: ‘Weg damit’. Ich aber sage: Eure Einstellung zum Krankhaften soll sein: ‘Ja, aber nicht so’” (von Weizsäcker, 1988b, p. 318-319).

³⁸ I thank Jan Helge Solbakk for introducing me to this movie.

³⁹ James Marcum also utilizes the play “Wit” and especially the character Jason Posner to discuss the role of care and competence in contemporary medical practice, “confronting” Posner with the writings of Francis Peabody about the importance of caring for the patient in medicine (Marcum, 2011).

loss of energy. As a highly recognized professor of Old English literature, specializing in the metaphysical poetry of John Donne, the mode of “nicht-können” is accentuated by her inability under these circumstances to engage in the work that constitutes the main part of her identity and self-satisfaction. In the movie we see from Vivian’s reactions how the lack of recognition of these parts of her situation add weight to the burden of her disease.

In von Weizsäcker’s emphasis on meeting patients with “yes, but not like this,” rather than with “away with it,” there is also a request to take the illness dimension into account when dealing with a patient. It reflects a desire to explore the disease in a biographical sense, tracing possible conditions in the patient’s biography that may be connected to the patient’s disease (von Weizsäcker, 1987d, 1988b). We are thus led to recognize and accept possible underlying processes of the disease, and so arises the “yes” by which his formula begins. Von Weizsäcker says: “However, the emphasis is on the Yes to the disease, which was not previously visible” (von Weizsäcker, 1987d, p. 355).⁴⁰ This request of von Weizsäcker to explore the patient’s biography in relation to understanding the disease and its possible “underlying” meaning suggests a possible relation to Freud and psychoanalysis. This is a path that I have chosen not to follow here in my reading of von Weizsäcker. Nevertheless, his encouragement to say Yes to the patient’s history also involves a Yes to the illness dimension of the patient, as an understanding of the patient’s ill-being also involves knowledge of the patient’s history. In the case of Vivian Bearing, knowledge of her work, her passion for literature and the sonnets of John Donne, her teaching experiences, and the fact that she has no family all give us insight into what this particular illness means to this particular individual human being.

In my view, meeting patients with “yes, but not like this” rather than with “away with it” represents an important prerequisite for care of the sort I am recommending. Here I argue in agreement with Martinsen and her suggestion that we approach patients in an attitude of reserve and receptivity. By this, we may come to see the patient with “perceiving eyes,” she argues, thus making us better able to recognize and to care for the patient’s needs, rather than “conquering”⁴¹ the patient by seeing her only as a neutral receptacle of our active interventions. It is not always necessary to initiate some practical action in meeting with the

⁴⁰“Aber der Nachdruck liegt auf dem Ja gegenüber der Krankheit, welches vorher nicht sichtbar war” (von Weizsäcker, 1987d, p. 355).

⁴¹ In Norwegian: “Erobre.”

patient; sometimes the consultation may profit from an attitude of reserve on the doctor's part, withholding medications, referrals to specialists, or sick leaves. We are trained to act, to initiate some kind of action, but in many situations such interventions may instead add insult to injury, both with respect to the risks connected to some procedures and tests, and to possible side effects of medications.⁴²

The underlying and pervasive attitude of “weg damit” in medicine thus represents an attitude that leaves little room for caring. To counter this attitude we need to reflect on the way we *see* patients in medicine, since seeing the patient with a purely recording gaze may enhance or facilitate a “weg damit” attitude in medicine, insofar as it focuses on reaching a diagnosis and looking for “solutions,” that is, what is to be done next for the patient. In the following section I try to deepen my reflection on the different gazes in medicine, further substantiating my claim that medicine's dominant eye is a recording eye.

4.2 Seeing in medicine

4.2.1 *The recording eye*

Even though the conditions in modern hospitals have changed since “the birth of the clinic” as described by Foucault, today's health care professionals, and first and foremost physicians, still build much of their knowledge on the “voyeur method of the human observatory—seeing without being seen” (Martinsen, 2006, p. 109). Patients are being observed from the outside, put in specific rooms for examination, with the aim of the examination to enable the physician to classify—“divide, sort, categorize, record”—to reach a diagnosis. As suggested in paper 1, this perspective is evident if we go to a recently updated textbook in clinical examination for medical students, where the authors point to how the examination really begins from “the moments you set eyes on the patient” (Epstein et al., 2008, p. 20). “As the patient approaches you in the consulting or examination room, observe the posture, gait and character of the stride,” and when making your initial acquaintance with the patient, “the grip of the handshake usually provides some useful

⁴² Of course, there is no antagonism between action and care; they are not necessarily mutually exclusive, and in many situations action is absolutely needed, including in situations involving care. Care can include practical action, and in palliative care in particular the practical and more “action oriented” aspects of care are inevitable.

information” (Epstein et al., 2008, pp. 20–21). The patient’s physique may indicate different conditions, reflecting a “constitutional shortness, a distinct genetic syndrome or the consequence of intrauterine, childhood or adolescent growth retardation”; the patient’s posture may also provide helpful information, with peritonitis indicated in a patient lying motionless, or pancreatitis in a patient lying with knees drawn toward the chest (Epstein et al., 2008, p. 21).

The further process of interviewing and examining the patient operates within a fixed framework, and even though physicians are encouraged to ask open-ended questions, the medical interview follows a standard pattern, investigating the patient’s social history, medical history, education, employment, medicines, drug and tobacco use, alcohol consumption, foreign travel, home circumstances, family history, and a review of the different organ systems, as well as the history of the present complaint(s). After the initial introduction and history taking, the physician inspects the patient’s body systems, looking for specific signs and stigmata, before she continues with palpation and auscultation of the heart and lungs. After finishing the general examination, the physician continues with a more specific, problem-oriented examination that is related to the particular problem(s) of the patient.

Perception or sensation plays a role in the medical examination, but this use of the senses differs from the perception Martinsen suggests. Here perception is used to search for specific signs that fit into a diagnostic scheme. For instance, the physician may palpate the abdomen or the thyroid gland, using her tactile sense to search for tumors; she auscultates the heart, listening for murmurs; she inspects the skin, looking for characteristic rashes; or she smells for characteristic odors, such as, for instance, acetone in the case of ketoacidosis. We may also add the sense of taste. A diagnostic indicator of cystic fibrosis is a salty-tasting skin, due to an abnormal high salt concentration in the sweat, a sign that is now accepted as almost pathognomonic for this fatal genetic disease. In ancient medicine, the physicians also tasted patients’ urine for sweetness, a clinical sign indicating diabetes.

We see from this that the medical exploratory gaze operates within a fixed framework, systematizing, differentiating, and classifying information about the patient within a predefined schema. From the first moment the physician sets eyes on the patient the examination begins, registering body language, clothing and hygiene, stature, posture, and handshake. Conversation with the patient usually follows an “anamnesic roadmap,” and

there is often little time or opportunity to deviate from this map. If the patient does start to talk about something outside these parameters, the physician often has strategies for redirecting the patient in order to get a focused anamnesis and reach a conclusion for the consultation. The usual way of approaching patients in medicine leaves little room for perception understood as an “openness toward the world,” to paraphrase Martinsen. On the contrary, the interaction may often be fixed, following a scheduled plan, and the physician aims at “disciplining” the situation so as to be able to finish.

If we return to a scene from the movie *Wit*, there is an encounter between Vivian and Dr. Jason Posner in which Vivian tries to approach Dr. Posner in a more personal way. They have known each other for some time while she has been at the hospital. Vivian has lost her hair as a side effect of her treatment, and struggles with anxiety and her fear of death. After Dr. Posner exchanges the usual phrases regarding her condition, referring to her blood tests and adjusting her drug dosage, Vivian addresses him for the first time by his first name, Jason, and asks him what he usually says to a patient who is apprehensive and frightened. “Of who?” the doctor replies, without perceiving her fear and apprehension. He seems not to even understand the question. “Well, I just... Never mind,” Vivian whispers back. Dr. Posner hesitates for a moment, then asks the patient if she knows the name of the president of the United States. He apparently interprets the situation as if Vivian has become confused, or at least he pretends to. So he starts to evaluate her level of consciousness by asking some standard competence questions. Vivian answers that she is fine. “Are you sure?” he asks. “I could order a test.” “No, I am fine, just a little tired,” Vivian replies. “Okay,” Dr. Posner says. “Listen. I have to go. Keep pushing the fluids. Try for 2000 a day. Okay?” “Okay,” Vivian whispers. By then the doctor is on his way out of the door.

Even though the scene might seem a bit exaggerated, it nevertheless points to some central features of a recording eye in medicine. First, it is clear that the medical world of Dr. Posner does not contain fear and anxiety. Occupied with details regarding the blood tests and tolerance of treatment, he fails to capture Vivian’s apprehension, instead interpreting it as a possible reduction of her level of consciousness. His recording eye may not have room for apprehension and fear. Instead he reaches out for a screening instrument and proposes to order some tests.

This is just a scene from a play and a movie. But recent empirical research also documents the role of this way of seeing in medicine. In their study “Clinical Essentialising: A

Qualitative Study of Doctors' Medical and Moral Practice," Kari Milch Agledahl and her colleagues recognize the uniformity of physicians' ways of seeing patients, pointing to how physicians actually "essentialize" the patients' stories by breaking them down into concrete complaints and categorizing the symptoms in medical terms (Agledahl, Førde, & Wifstad, 2010). In another study, Agledahl et al. (2011) show how the doctors being studied by observation actively direct the focus *away* from the patient's existential concerns onto medical facts and rarely address the personal aspects of a patient's condition. They conclude that the main failing of patient-doctor encounters is not a lack of courtesy, but the moral offense patients experience when existential concerns are ignored:

The doctor avoids obvious existential concerns; when the patient talks about the tumour, the doctor does not address the underlying fear but asks about symptoms. Likewise, when the patient's increasing tiredness is brought up, he is made to quantify his activity levels. Explicit worries are met with medical answers, and the patient's dying process is even described as "a catabolic condition." The tacit existential dimension appears uncomfortably present at the end, when the fears that are unaddressed seem to prevent the patient from leaving. (Agledahl et al., 2011, p. 652)

The description that Agledahl et al. offer here may be said to be consistent with the description of the recording eye, as outlined by Martinsen, where tiredness is met with a quantitative measure of activity and conceived of as a catabolic condition. It illustrates how physicians confine themselves to their medical repertoire in meeting with their patients' suffering. The physicians continue recording in meeting with the patients' conditions, and by the process of "essentializing" and by actively directing their focus away from the patients' existential concerns, they never get into "the perceiving range of life" (Martinsen, 2006).

It may be relevant to ask whether this ignorance of existential matters is due to indifference. Is the recording eye an indifferent eye? According to the Norwegian philosopher Arne Johan Vetlesen (1994), indifference and distance are the prime threats to morality: "Given a detached attitude, there is a danger that I shall remain blind to the human reality of the situation in front of me, that it will awaken no engagement on my part but will instead leave me indifferent. And indifference is a prime threat to morality, even more destructive to it than hatred or resentment" (Vetlesen, 1994, p. 10). In my view, emotional indifference may

be one part of the process of recording, related to the loss of perception and lack of a “seeing emotion,” to paraphrase Martinsen. However, the process of recording involves something *more* than the loss of perception and a lack of emotional involvement. It also relates to the tradition of medicine and its ideals of professionalism and objectivity in the wake of the processes that Foucault points to in his analyses of the medical gaze. To this, we may add the influential professional ideal of *detachment* in medicine (Halpern, 2001), which I will enlarge upon later in the thesis. Kari Martinsen does not speak of detachment in elaborating her conception of the recording eye. But the lack of connectedness between professional and patient is obvious when she describes how the professional, displaying a recording gaze, “does not present himself as a person in relation to the patient” (Martinsen, 2006, p. 108), and how “the professional is withdrawn and closed in relation to the other,” offering “nothing of himself in the relation” (Martinsen, 2006, p. 108).

4.2.2 The perceiving eye

As a response to my claim that the main gaze in medicine is the recording gaze, I argue in favor of implementing a perceiving eye in medicine. In the following I will outline some ethical implications of this way of seeing patients in medicine, as well as enlarging on what I call as the epistemic potential of care, that is, the epistemological implications of seeing patients with a perceiving eye.

The recording eye is powerful in its objectification of the other. Through a recording eye, we may see a person as an object, and this may threaten the person’s integrity. The idea that individuals are not reducible to objects, but are intrinsically valuable, constitutes the core of the conception of morality, human dignity, and integrity (Kant, 1997). Integrity means that which must not be hurt, damaged, or altered, but which should be respected and protected (Kemp, 2000), and for a person to be seen as an object may be both painful and damaging. In paper 1 I offer the example of a woman suffering from self-mutilation and suicidal thoughts (Ribe, 2009) who precisely delineates the damaging effects of a recording eye, describing how she feels like “a scrap, a nothing” when treated by a doctor who just sutures her wounds in a professional manner, without even talking to her (Ribe, 2009). We see how Vivian Bearing collapses and withdraws as she experiences that Dr. Posner does not manage to treat her as anything but a medical case, even when she directly approaches him. Dr. Posner not only allows for the objectification of his patient, he also fails to strengthen the patient’s courage in suffering. Being able to see the patient with a perceiving eye may

contribute to bringing forward the patient's courage to live (Anvik, 2004). "We must be able to both see and express the appeal for help to strengthen the life courage in suffering," says Martinsen (1993, p. 9). If we manage to see the patient's need, and express the impression that the patient makes on us in terms of a word, a gesture, or a practical action, we may contribute to strengthening the patient's courage to further endure his or her disease. The woman suffering from self-inflicted wounds in paper 1 noticed that a physician's hands were trembling while he was suturing her wounds. This expressed emotion on the part of the physician indicated to her that she was not just pure routine for him, but actually moved him—something that "was very good to feel, to take with me outside" (Ribe, 2009, p. 780).

A caring approach may sometimes be epistemically essential in the clinical encounter. In paper 1 I illustrate this potential of the perceiving eye for gaining *clinically* relevant information by using an example from general practice, a patient who seeks the physician because of the relatively simple condition of impacted earwax. But the whole consultation ends in a personal disclosure by the patient, who tells about a childhood filled with violence and abuse. In his appointment with this patient the physician is moved by what seems an extra weight in the patient's step, or something in the patient's eyes. By being aware of his own "seeing emotions" in meeting with the patient, the physician is able to capture some important information regarding the patient's clinical situation. By being open and non-judgmental, having an attitude of reserve and receptivity, the physician manages to uncover the underlying worry of the patient. Instead of rapidly closing the consultation once its initial purpose is resolved, the physician remains, being receptive to the patient, thus managing to capture the patient's appeal for help. This way of seeing involves not only an openness to the patient's vulnerability, but also an openness toward the physician's *own* vulnerability. It requires the development of an awareness in the doctor toward his own feelings. Such an openness to affective cues in the clinical encounter may represent a precondition for a complete understanding of clinical realities, contributing to "sharpening" that clinical intuition, which is necessary for competent medical treatment and care (Nortvedt, 2008a).

Of course, interpreting the physician in the case above as an example of openness and sensibility to affective cues may be just poor speculation. Maybe the physician simply asked the patient one more time how he was doing out of an old habit, or as a pure reflex, or out of

politeness. What was really going on we cannot know for sure. Let me therefore offer one more example from the doctor's examining room that illustrates this way of seeing patients in more detail. In this case the physician tells the story herself.

In one of her books Eli Berg describes a patient consultation where she manages to see and perceive a patient in a different light than in her previous consultations with him, and tells how this leads to a different understanding of the patient as well (Berg, 2005). The patient is well known to Berg. He is a carpenter who has had problems with his back for many years. Berg now suspects that he is trying to get sick leave from his regular job in order to work in the "black market." Berg has known this patient for 15 years, and does not like him very much. She knows he has problems with alcohol and aggression. "There is always a coldness following Nilsen," Berg writes (Berg, 2005, p. 105). This time his back pain seems even worse. He hobbles around with his face wreathed in pain. "You are acting well today," Berg silently resonates (Berg, 2005, p. 105). When the patient is finally seated in the examination room, his hair is wet from sweat, and his face and neck are flushed. Once again he complains about his "damn back."

I look at him, and suddenly it is as if I see past him, that his face in a way becomes transparent. I perceive a lived life. I think of his childhood; maybe he was not wanted when he arrived in this world. Maybe nobody had showed him how valuable he was, given him courage and a joy for life. ... Suddenly, I perceive a human being thrown into the world without having asked for it. Like we all are. ... I feel hit by a consciousness of how vulnerable we are as human beings. ... In a short second this stands for me as an appeal, as a cry from time immemorial: Do you see me? Do you hear me? Without a reply we cannot live. (Berg, 2005, pp. 106–107)⁴³

Berg describes how the man's unsympathetic traits are brushed aside, and how she relates herself to a lived life, a person, a human being. For the first time the patient has eye contact with her, and he cries. Then it is silent for a long time before he tells her that on the

⁴³ "Jeg ser på ham—og med ett er det som jeg ser forbi ham, at ansiktet på en måte blir transparent. Jeg fornemmer et levd liv. Jeg får tanker om at han kanskje ikke var ønsket da han kom til verden. Kanskje hadde ingen vist ham hvor verdifull han var, gitt ham livsmot og livsglede. ... Med ett aner jeg et menneske, kastet inn i verden uten å ha bedt om det selv. Som vi alle. ... Jeg føler meg truffet av en bevissthet om hvor sårbare vi mennesker er, ... I et lite sekund står dette for meg som en bønn, et rop fra uminnelige tider: Ser du meg? Hører du meg? Uten gjensvar kan vi ikke leve" (Berg, 2005, pp. 106-107).

previous weekend he beat up and almost killed his girlfriend, with whom he had been living. He now lives alone; his now ex-girlfriend owns the apartment, and he has lost his job because of alcohol. And his aching back torments him. Berg reflects on the radical change that she experiences in her meeting with the patient. “To like or not like, that is not what it is about for me this day,” she writes. “I am taken by surprise by something I cannot put in words” (Berg, 2005, p. 107). She puzzles, “how could I be so moved by this patient, whom I have tried to avoid for years?” (Berg, 2005, p. 108).

What Berg offers here is a description of how perception may open the way for a more comprehensive understanding of the patient. As Martinsen would express it: By being perceptually open in meeting with this patient, the perception is condensed to an impression, which again is expressed in tone and gesture toward the patient. Berg is “in the situation with her whole strength in order to express the impression” (Martinsen, 2003b, p. 139), and through this she gains new knowledge regarding the patient and his condition. This kind of knowledge is different from the conceptual knowledge she usually relies on in dealing with patients’ aching backs, which is to focus on whether the pain relies on muscle tension, or nerve compression, or some kind of internal pathology. According to the biomedical model we trace different differential diagnostic paths in order to find the right diagnostic category. Following the biopsychosocial model, we might also consider possible psychological or social factors. However, the insight Berg gains in this new perception of the patient is of a different kind than just reflecting over possible causes of the patient’s pains. Entering into “the perceiving range of life,” Berg describes how she is struck by the patient and the situation he is in, regardless of her previous dislike of him. She receives an impression from the patient, and reacts to it by looking into his eyes for the first time. As Martinsen points out, we may express our impressions by a “good gaze,” or a warm tone, or by careful hands. And this expression of care establishes a new contact between Berg and the patient: They have eye contact for the first time, and the patient reveals additional useful information about his situation.

4.2.3 An ambivalent eye?

Of course it is not always that simple to either perceive or record in meetings with patients. If we return to the movie *Wit* and the scene between Dr. Jason Posner and his patient Vivian Bearing, we sense an ambivalence in Dr. Posner’s behavior when Vivian addresses him in a personal way. He hesitates, he seems a little confused, before he continues with his

schemes, his phrases, and his tests. Even though he is practiced at the recording gaze, he seems to be uncertain when confronted with his patient's more personal request. "It is difficult to be recording only," says Martinsen (2006, p. 83). She relates this difficulty to the behavior of the Priest and the Levite in the story of the Good Samaritan. Before they retreated to the safety of the recording gaze, a struggle may have taken place in them, she suggests. She refers to the Danish translation of the Bible, where it is written that both the Priest and the Levite saw the man and "went around." The suffering of the half dead man must in some way or other have moved them, as they walked around and not right past: "It thus seems to have been a struggle in their eyes between seeing participatingly and seeing recordingly, and that it is difficult to be recording only" (Martinsen, 2006, p. 83). Such a struggle we may also perceive in the eyes of Dr. Jason Posner in the scene where he finishes his first pelvic examination of Vivian Bearing. It is obvious that he is overwhelmed by what he has found in the examination; he seems excited, worried, and uncertain at the same time. However, instead of approaching the patient in pain, he quickly leaves the room. May this sort of incoherent behavior represent an expression of a struggle inside him between perceiving and recording, between seeing the patient with her pelvis full of tumorous masses recordingly, and seeing her with perceiving eyes, thus facing her serious condition and the fact that she will soon die?

From where may this ambivalent struggle originate? So far, I have pointed to the underlying attitude of "weg damit" in today's medicine and the process of recording, as representing possible obstacles for caring in medicine. In the next section I will address this ambivalence in connection with the model of the moral actor in medicine and medical ethics, and the way that care is traditionally conceived of in medicine.

4.3 The moral agent in medical ethics: Autonomous and alone?

Based on my work so far, I suggest that medicine and medical ethics conceive of the moral agent as being a detached and separate self (Martinsen, E. H., 2011b). To substantiate this claim, I will elaborate further on how this ideal of the moral agent may be traced in some of the ethical discourse in medicine. Here I rely on Jodi Halpern and her analysis of what she denotes as *the modern ideal of detachment in medicine* (Halpern, 2001), and I draw as well

on the care critiques of autonomy (Verkerk, 2001; MacKenzie & Stoljar, 2000; Donchin, 2000, 2001).

Halpern sees the ideal of detachment as originating from the development and cultivation of the tradition of detached concern and objectivity in medicine, represented by scholars like Howard Lief and Reneè Fox (1963), Charles Aring (1958), and Herrman L. Blumgart (1964). Lief and Fox first introduced the term of “detached concern” in a study, where they describe the program or process that medical students are taught to go through in order to detach themselves from emotional involvement with patients (Lief & Fox, 1963). They argue that detached concern and empathy are, in fact, synergistic, and that the physician is better able to be empathic when he suppresses or avoids emotional involvement with patients. In another study, Charles Aring (1958) proposes a conception of empathy that is detached from sympathy. In his view, what is at stake for the physician is to avoid becoming incapacitated by the problems arising from a patient’s emotional state. On the contrary, the physician must remain separate from these problems to be effective in treating the patient. Blumgart (1964) proposes what he calls “neutral empathy,” in which detachment and cognitive skills are considered mandatory to understand a patient’s emotional state. The development of emotionally detached concern may also be a response or reaction to the value of sympathy in medicine, as suggested in the works of Worthington Hooker (Halpern, 2001; Marcum, 2008). At the beginning of the 20th century, to be sympathetic was considered to be unscientific, and “emotionally detached concern was heralded as a critical component of medicine’s social structure, especially in terms of the patient-physician relationship” (Marcum, 2008, p. 260). The two main assumptions of detached concern in medicine are thus *objectivity* and *neutrality*, toward the patients’ emotions as well as toward one’s own emotional state as a physician.

The importance of maintaining a neutral emotional state as a physician was also emphasized by Sir William Osler. Osler is well known for his humanistic and caring approaches toward patients. At the same time, he elaborates on the virtues of *imperturbability* and *equanimity*, presenting an ideal of the physician as cool, maintaining presence of mind “under all circumstances.” The first virtue is imperturbability, which refers to “coolness and presence of mind under all circumstances, calmness amid storm, clearness of judgment in moments of grave peril” (Osler, 2010, p. 2). Such poker-faced composure, Osler claims, is essential to instill confidence in impressionable or frightened patients. An important companion to

imperturbability is equanimity. Equanimity, or “*aequanimitas*” in Latin (a word derived from *aequo animo*, “with even mind,”), represents the mental equivalent of imperturbability, an ideal state of the physician, representing objectivity in the interaction with patients even when it comes to the patients’ emotions. To reach the state of equanimity, the physician must detach from his own emotional response to the patient, including bodily emotions and reactions; this is important in order to be able to “see into” the patient’s “inner life.” Thus Osler extends the ideal of “objectivity,” which had already shown its utility in the understanding of disease processes, to physicians’ observations of patients’ emotional lives (Halpern, 2001). To get access to the patient’s emotional life, he encourages us to see with an eye detached from our own emotions. This element of equanimity has been the subject of some debate among Osler scholars: While some have interpreted it as apathy, as the absence of emotions, others have read it as “*metriopatheia*,” measured or moderated emotions (Sokol, 2007).

In his plea for detachment, both physiologically, as expressed by the virtue of imperturbability, as well as emotionally and mentally through the virtue of equanimity, Osler reinforces an ideal in medicine of the neutral physician’s perspective, being “free of bias, that is, free of his situatedness” (Halpern, 2001, p. 23). In a recent edition of *Principles of Biomedical Ethics* by Beauchamp and Childress (2009), the importance of cultivating detachment alongside compassion in the education of health care personnel is also emphasized: “The language of *detached concern* and *compassionate detachment* appropriately appears in health care ethics expressly to identify a complex characteristic of the good physician or good nurse” (Beauchamp & Childress, 2009, p. 40).

The assumption that the physician needs to be “free of his situatedness” to be able to objectively obtain access to the emotional lives of patients provides us with some further clues to understanding the moral self in medicine. In following the ideal of detached concern and equanimity, the physician must endeavor to remain *separate* from personal, situational, and relational clues when interacting with patients. Consequently, in a model of detached concern, patients and professionals remain two “separate parties” (More, 1994), emerging as *separate selves*.

The understanding of the agent as a separate self also needs to be discussed in relation to the prominent role attributed to autonomy in medicine, and may be considered as a possible “adverse effect” of the current emphasis on autonomy in medicine and medical ethics.

Respect for patient autonomy has been the cornerstone of medical ethics for several decades, thus “liberating the self” from paternalistic medical structures (Solbakk, 2011), and it came into medicine primarily as protection against abuse in the name of science. In the aftermath of World War II and the disclosure of human exploitation in medical experimentation, there was a call for greater protection of research participants, and the Nuremberg Code of 1947 declared that the voluntary consent of the human subject is absolutely essential. The idea of patient autonomy was also carried over to clinical medicine, and subsequently developed as a response and a correction to the practice of medical paternalism, where physicians “knew best” and often treated patients without the patients’ knowledge about and consent to what was happening. The word *autonomy* is derived from the Greek *autos* (“self”) and *nomos* (“rule,” “governance,” or “law”). Personal autonomy encompasses, at a minimum, “self-rule that is free from both controlling interference by others and from certain limitations such as an inadequate understanding that prevents meaningful choice” (Beauchamp & Childress, 2009, p. 99). Virtually all theories of autonomy incorporate the two conditions of *liberty* (independence from controlling influences) and *agency* (capacity for intentional action) as essential.

One of the most influential theoretical frameworks in (bio)medical ethics is the four principles approach of Beauchamp and Childress (2009). Their formulation of the principle of autonomy as respecting autonomous choice, and the specification of it in the form of informed consent, has had a great impact within academic medical ethics, medical education, and clinical practice. The principal mechanism for respecting and safeguarding patient autonomy in clinical settings is the process of informed consent, whereby the competent patient agrees to a proposed therapy after having received clear and adequate information. The patient’s decision is supposed to be made voluntarily, free of external coercion or distraction. For this reason, the discussion regarding autonomy, or self-determination, often focuses on two dimensions: the decisional capacity of the patient and freedom from external coercion.

Jodi Halpern describes how physicians, in order to respect patient autonomy and the patient’s right to freedom from external coercion, may be guided by a norm of negative autonomy, which is understood as “constraint from interfering with a patient’s self-determination” (Halpern, 2001, p. 102). Autonomy may thereby be interpreted in a negative sense, understood as *freedom from* interference. Beauchamp and Childress refer in this

connection to autonomy as a negative obligation: “Autonomous actions should not be subjected to controlling constraints by others” (Beauchamp & Childress, 2009, p. 104). A practical consequence for medicine of such an understanding of autonomy may be that patients risk being left alone when they have to deal with difficult decisions. That is, the fear of interfering or of representing a controlling constraint on the patient may be perceived as greater by the physician than the danger of leaving the patient alone. In such a climate we can trace the idea of an independent, separate self that is free from constraints from others’ interference and connectedness: We can trace the idea of a self that is *autonomous and alone*. The traditional ideals of autonomy thus give normative primacy to independence, self-sufficiency, and separation from others, at the expense of a recognition of the value of relations of dependency and interconnection (MacKenzie & Stoljar, 2000). In response to this, both feminist ethicists and care ethicists have criticized the idea of autonomy as neglectful and as lacking an appreciation of the social and relational basis of human agency and health values:

Western philosophy, ever since the Cartesian turn, has been captivated by a paradigm of personal agency that incorporates two dubious assumptions: that individuals are isolated ahistorical monads and that the choices available to them are extracted from a fixed and immutable set of options. According to the conception of personal autonomy implicit in this model of agency, individuals are separated from one another by sharp boundaries that can be justifiably breached only by the consent of self-determining subjects. This contract-like picture of human relations has come under increasing scrutiny in recent years, but it still operates as *the leading paradigm structuring professional-client relations, particularly between healthcare providers and patients*. (Donchin, 2000, pp. 187–188, my italics)

Versions of feminist ethics and care ethics have sought to revise this individualistic and atomistic conception of autonomy through the conception of *relational autonomy* that centers on the conviction that persons are socially embedded and that agents’ identities are formed within the context of social relationships (Mackenzie & Stoljar, 2000; Donchin, 2001; Verkerk, 2001; Sherwin & Winsby, 2010). The care critique of autonomy thus points to how the idea of a self as free and independent may have led to the values of trust, care, and responsibility being neglected in moral discourse. These critics argue that we instead should promote the ideal of interdependency and reciprocity, where the individual’s

autonomy cannot be viewed in isolation from other people but must be viewed in relation to others (Verkerk, 2001).

From this we see how an understanding of autonomy as freedom from interference conflicts with the moral injunction of care ethics of “not turning away from someone in need” and may lead to situations in medicine where patients are left too much to themselves when facing difficult situations. Halpern recognizes this tendency as she points to how seeing autonomy as freedom from interference may lead to a practice in which physicians tend to leave patients alone, often without social supports, to face difficult medical decisions (Halpern, 2001). According to the care critique of autonomy, the danger of abandoning people, thus possibly inflicting relational harm in order to respect autonomy, represents an important objection to the overall dominance or overemphasis on autonomy in Western ethics (Verkerk, 2001). This is a critique that is seldom focused on in medical ethics.

I have previously pointed out that one implication of the relational ontology of an ethics of care is an accentuation of features different than those most salient in ethical theories that conceive of the self as free and separate from others. The possibility of relational harm, as well as agents’ vulnerability and dependency, are important implications of a relational ontology. That these differences in the understanding of the moral agent may lead to different attitudes and practices in relation to care seems obvious. This is one of the reasons I consider the underlying understanding of the moral agent as “autonomous and alone” in medicine and medical ethics to represent an additional reason for medicine’s ambivalence toward care.

Another reason, which I will elaborate upon below, may be in the way care has traditionally been conceived of in medicine. In the following section I trace care in medicine, focusing on its understanding of care in terms of the virtue of compassion, as well as in terms of its ideal of beneficence.⁴⁴

⁴⁴ There are of course other areas that should have been elucidated in relation to this aim of tracing medical expressions of care, and among them is the empathy discourse in medicine, as well as the notion of medicine as an art. In this thesis these two areas are treated only briefly. However, the understanding of empathy in medicine and the characterization of medicine as an art represent interesting areas for further research in order to develop and further refine a care perspective in medicine.

4.4 The medical man of virtue

By motivating the sensitivities of individual medical practitioners, both sympathy and compassion have exerted a strong influence on caring for the sick in times past. Codes and oaths throughout the ages have exhorted us to care for the sick from motives of compassion and sympathy (Reich, 1995b). We may follow the tradition of sympathy in medicine back to the Hippocratic period, when the physician's capacity to heal sufferers was conceived of as deriving from a specific *philia* that the physician developed for the patient (Halpern, 2001). John Gregory (1724–1773) spoke of “the sensibility of heart that makes us feel for the sick and arouses in us the desire to relieve their distresses” (Reich, 1995b, p. 332), and Worthington Hooker claimed in 1849 that the physician influences patients therapeutically by interacting emotionally with them (Halpern, 2001).

In the late 19th and early 20th centuries, however, there was a shift in attitudes toward caring in health care. This shift may be related to the rise of allopathic medicine and its emphasis on the natural sciences, as well as to medical advances like the development of anesthetics, the discovery of micro organisms, and the development of antibiotics and insulin (Howell, 2001). These changes led the physician away from the patient's bedside and into the laboratory or the operating theater, and humanistically oriented “caring for” was pushed to the periphery of medicine for the benefit of an ethic of competence, and an attitude of “taking care of” (Reich, 1995b). The “caring for” received an impetus, though, during the 1920s, first and foremost through the work of the physician Francis Peabody. Peabody wrote an essay about the nature of care in medicine, arguing in favor of “caring for” the patient as essential to the practice of medicine, as a response to the fast-developing technical art of medicine (Peabody, 1927; Marcum, 2011). Peabody argues that physicians must not know only about disease mechanisms. It is equally important that the physician also know what the disease means to patients in terms of their illness experience and life story. Here Peabody argues in line with von Weizsäcker and his call for a medicine that also teaches the ill person. It is interesting that they wrote their articles just one year apart: Peabody published his article in 1927, and von Weizsäcker wrote his essay “Der Arzt und der Kranke” in 1926. Following Peabody's plea for care, there have been scattered contributions advocating a caring perspective in professional attitudes, practices, and moral analysis of medicine (Menninger, 1975; Benfield, 1979). Among the most influential are the

works of Edmund D. Pellegrino and David C. Thomasma on medical virtues and beneficence in medicine (Pellegrino & Thomasma, 1988, 1993).

4.4.1 Care as a virtue of compassion?

Pellegrino and Thomasma's interest in virtue ethics stems from a desire to enrich principle-based ethics, pointing among other things to how this form of ethics fails to take into sufficient account the *character* of the agent (Pellegrino & Thomasma, 1993). According to Pellegrino and Thomasma, virtue is an irreducible element in medical ethics, and they opt for the classical definitions by Aristotle and Thomas Aquinas when it comes to defining the concept.⁴⁵ In their analyses of the virtues of medical practice, Pellegrino and Thomasma discuss fidelity to trust, phronesis, justice, fortitude, temperance, integrity, and self-effacement, as well as compassion (Pellegrino & Thomasma, 1993). Here I will focus only on the virtue of *compassion* because of its relevance to care. Pellegrino and Thomasma understand compassion as a moral virtue in the classical sense of the word, that is, as "a habitual disposition, to act in a certain way" (Pellegrino & Thomasma, 1993, p. 79), and they connect it to what they call the "caring bond," which includes healing, caring, and curing. "Compassion is the character trait that shapes the cognitive aspect of healing to fit the unique predicament of *this* patient" (Pellegrino & Thomasma, 1993, p. 79). According to Pellegrino and Thomasma, compassion is an essential virtue of medical practice. They point to how the call for compassion in medicine and health care goes directly to their own central concern, "the character of the physician" (Pellegrino & Thomasma, 1993, p. 19). The very etymology of the term strongly suggests the idea of co-suffering: "To be compassionate is to be disposed to see, as well as feel, what a trial, tribulation, or illness has wrought in the life of this person's here-and-now suffering" (Pellegrino & Thomasma, 1993, p. 80). They see compassion as a compound of affect, attitude, word, gesture, and language, but they also conceive of compassion as a virtue in the classical sense, which means that it includes both a moral and an intellectual component. It is also related to emotional states. Where the moral aspect of compassion relates to the fact that compassion may be indispensable to attaining the end of medicine, which is to heal, help, and cure, the

⁴⁵ Aristotle defines virtue as a "state of character" that "brings into good condition the thing of which it is the excellence and makes the work of that thing to be done well" (Aristotle cited in Pellegrino and Thomasma, 1993, p. 5). In equating virtue with character, Aristotle was being faithful to the Greek meaning of the word *ethikè*, which means "character" (Pellegrino and Thomasma, 1993).

intellectual aspect relates to a disposition to comprehend, assess, and weigh the patient's predicament in relation to the end of healing, helping, and curing.

Pellegrino and Thomasma distinguish compassion from empathy, mercy, sympathy, and pity, even though these affective states may be more or less closely related. Compassion focuses on co-experiencing another's suffering; "it includes an ability to objectify what another person is feeling in symbolic form, that is, in our speech, our body language, and in our participation in the 'story' of the other's illness" (Pellegrino and Thomasma, 1993, p. 82).

4.4.2 Care as *beneficence*?

Beneficence applies to the practice of good deeds, and, understood as a principle, beneficence has marked the ethical codes of physicians since antiquity. As a principle that guides decisions, it should be distinguished from the virtue of benevolence, or kindly feeling, that motivates actors. In medical ethics beneficence is part of the four-principles approach of Beauchamp and Childress. They use the term to cover beneficent action more broadly, so that it "includes all forms of action intended to benefit other persons" (Beauchamp & Childress, 2009, p. 197). This implies an active contribution to the welfare of others; agents must take positive steps to help others, not merely refrain from harmful acts. For Beauchamp and Childress there are two aspects of beneficence: positive beneficence that requires agents to provide benefits to others, and utility that implies a balancing of benefits, risks, and costs (Beauchamp & Childress, 2009). They furthermore distinguish between obligatory beneficence and ideal beneficence, and point in this connection to the parable of the Good Samaritan: "Common interpretations of the parable suggest that positive beneficence is more an *ideal* than an *obligation*, because the Samaritan's act seems to exceed ordinary morality" (Beauchamp & Childress, 2009, p. 198). They refer to the consciousness of limit that is inherent in the common morality in relation to beneficent acts: "Virtually everyone agrees that the common morality does not contain a principle of beneficence that requires severe sacrifice and extreme altruism" (Beauchamp & Childress, 2009, p. 198). And they continue: "Everyone agrees that only ideals of beneficence incorporate such extreme generosity. Likewise, we are not morally required to benefit persons on all occasions, even if we are in positions to do so" (Beauchamp & Childress, 2009, p. 198). We see from this that beneficent conduct in the generous sense of the word constitutes an ideal rather than obligation. Beauchamp and

Childress refer here to common morality as a source for limiting the scope of beneficence in order not to end in self sacrifice and extreme altruism.

Pellegrino and Thomasma present a different approach to beneficence in medicine and medical ethics, one in which they aim to redefine, and refine, the notion of beneficence as a reaction to the two major ethical theories that are “vying for dominance in medical ethics,” namely, the deontological and the utilitarian approaches (Pellegrino & Thomasma, 1988, p. 3).⁴⁶ They argue that such a “third theory” based on beneficence and virtue in contrast to the prevailing focus on principles is more appropriate to the special context of the medical encounter today. In their book they contend that beneficence remains the central moral principle in the ethics of medicine. It entails more than the negative principle of *primum non nocere*, including positive enhancement of the components packed into the notion of *the patient’s good*. Patients seek not only to be protected from harm, they argue, but also “to be healed and to have health restored or improved, pain and anxiety relieved, disability lessened” (Pellegrino & Thomasma, 1988, pp. vii–viii). Central to their understanding of beneficence is the notion of “the patient’s good,” and in this connection they highlight the process of *healing* and the *healing relationship* between patient and physician, defining the end of medicine as a right and good *healing action* for each particular patient.

4.4.3 A gentleman’s care?

Care in medicine is thus related to the altruistic virtue of compassion and the principle of beneficence. So, why bother with introducing care and care ethics into medicine, instead of focusing on compassion or beneficence? What may a care perspective add to medicine? I indicate some possible advantages in paper 2, where I point to how the traditional understanding of care in medicine, seeing care as a virtue or as a principle of beneficence, misses important dimensions of care emphasized by “modern” care ethics, especially its relational understanding of care. In the following section I further enlarge upon this claim.

One objection to the potential of the principle of beneficence for encompassing care relates to its utilitarian and deontological heritage. An injunction to produce the maximum good runs the risk of harming a minority for the sake of benefiting the majority. So the principle

⁴⁶ Pellegrino and Thomasma wrote this book in 1988. Since then the field of medical ethics has evolved to include a broader range of ethical perspectives, like casuistry, narrative ethics, the virtue ethics that Pellegrino and Thomasma themselves proposed, and also subsequent elaborations of an ethics of care.

of beneficence may be incompatible with an understanding of care and an ethics of care (Pettersen, 2008). Furthermore, because of that same utilitarian and deontological heritage, the principle of beneficence may have a tendency to promote an ideal of disinterested beneficent deliberation and action (Churchill, 1995). Such an ideal of disinterested beneficence differs from the basic requirements of care, of being connected, engaged, and present in the relation. It may also be argued that whereas a principle of beneficence identifies promoting the patient's good as a requirement for right action, an ethics of care also suggests a feeling response directed to the object of care, as well as a personal commitment to the patient (Reich, 1995b).

If we go to the work of Pellegrino and Thomasma, their emphasis on the healing relationship and the process of healing may be compatible with a care orientation's emphasis on relation and on responsiveness to particular others (Sharpe, 1992). However, operating as they do within a framework of virtue ethics, they tend to concentrate on the *disposition* of the physician to act in a compassionate, caring way, instead of taking the healing *relationship* as their main point of departure. They do speak of the healing relationship; however, in their account of the virtue of compassion they do not focus on this relationship with its inherent practices, competencies, or potentials for harm, but rather highlight the moral, cognitive, and emotional aspects of the virtue in sole relation to the physician as an agent. Thus, they tend to define the relationship in terms of the physician's character, dispositions, and competencies. Besides, in their account of the virtue of the physician and the end of medicine, they say little about the processes *in between*, or the relation between physician and patient. Instead of trying to comprehend what goes on in this healing practice, thus exploring the relation between the physician and the patient, they highlight the physician's abilities and competencies. These two ways of approaching the relationship between physicians and patients thus reflect an important difference between an ethics of care and virtue ethics.

Virginia Held warns against seeing compassion and caring as similar: "the caring promoted by the ethics of care is quite far from compassion," says Held (2006, p. 34), thus denying that care is an altruistic disposition of individual and psychological motivations. "This misses the heart of what goes on in practices of caring and misses what is of most value in them, which is that they are caring *relations*" (Held, 2006, p. 35). Held is one of the critics of seeing care as entirely or primarily a matter of motive or virtue. In seeing care simply as

a virtue, we miss a central feature of care, namely, “its evaluations of and recommendations concerning relations *between* persons,” says Held (2006, p. 52). Where virtue theory focuses on the individual and her/his dispositions, care ethics focuses on relations between persons. To be a caring person requires more than the right motives and dispositions toward others: “It requires the ability to engage in the practice of care, and the *exercise* of this ability” (Held, 2006, p. 51).

The understanding of virtue suggested by Held may be questioned, though. Virtues may be conceived of as relational in nature, comprising character traits that are admirable to others for a variety of reasons, including the extent to which those virtues produce good outcomes for others. That is, to seek to be virtuous is not to be concerned with oneself alone and with one’s own state of virtue; one is not virtuous for the sake of one’s self, but for the sake of others who are benefited by one’s virtue.⁴⁷ In spite of this, I find the argument of Held to be of value as we ask whether care may be conceived of as a virtue in medicine and medical ethics.⁴⁸ That is, even though a careful analysis of a given virtue may reveal some relationality, I do not share the view that emphasizing care as a virtue is able to capture the full depth of the relational dimension of care, and certainly not in medicine, where the ideal of detachment and non-interference has been dominant. By arguing that physicians should remain detached and “free of situatedness” in meeting with their patients, we miss important prerequisites for caring in the first place. Furthermore, focusing on the individual characteristics or attributes of the physician, and on their possible implications for the patient, may contribute to maintaining, rather than challenging, the ideal of a detached, separate self. In my view, part of the ambivalence that is to be found toward care in medicine today is due to this “gentleman’s-care” notion of care, of viewing care as a virtue of the detached and emotionally equable physician. By using the expression “gentleman’s care” I intend to suggest a kind of care void of the relational “in between,” where the carer may be conceived of as distant and polite rather than present in the relationship. I have

⁴⁷ I thank Stan van Hooft, who reviewed an early draft of some parts of this work, for this comment.

⁴⁸ Whereas Held does not approve of care ethics being associated with virtue ethics, others argue for categorizing care ethics as a species of virtue ethics, with care as a central virtue (Tong, 1998; Halwani, 2003; Curzer, 1993, 2002; Slote, 2007). Nursing theorist Patricia Benner argues in favor of a dialogue between care ethics and virtue ethics (Benner, 1997). Benner highlights the need to articulate and attend to the moral art of attentiveness and caring relationships in health care practices, which may protect patients in their vulnerability while fostering growth and limiting vulnerability. “This calls for bringing caring practices in from the margins of our thinking about practice and combining care and virtue ethics,” Benner (1997, p. 59) argues.

difficulty seeing the relational qualities of a physician caring for a patient being fully present in the relation if at the same time the physician is striving for emotional and physical detachment. What is it to care for a patient, anyway, if we at the same time aim for separation, detachment, and non-interference? By losing the relational qualities of care, we also risk losing our curiosity about the patient, and we risk becoming preoccupied with our own agenda, driven by the recording eye, thus losing sight of the patient even though we are courteous and friendly during the consultation.

Held points to the fact that virtue theory has until very recently not paid much attention to the practices of caring in which women have been so heavily engaged: “The traditional Man of Virtue may be almost as haunted by his patriarchal past as the Man of Reason. The work of care has certainly not been among the virtuous activities to which he has adequately attended” (Held, 2006, p. 20). I find this argument particularly relevant to the fields of medicine and medical ethics, in which the allied dichotomies of male/female, physician/nurse, curing/caring have been dominant, and in which the care work, for the most part, has been done by nurses. Furthermore, I believe it is appropriate to ask whether the understanding of care in medicine may have been influenced by the patriarchal heritage of “the medical Man of Virtue.” The history of medicine is full of examples of excellent clinicians, proficient medical doctors who managed as well to be “clinical artists” caring for their patients. Often when authors or practitioners are trying to embody the notion of the art of medicine, they draw on examples or anecdotes of excellent and extraordinary (male) physicians (Colgan, 2009), thus reinforcing this picture of the medical Man of Virtue. In the new situation of medicine today, when an increasing share of the physicians are female, I welcome a perspective on care that also draws on perspectives from feminism and nursing.

To sum up, I have argued that understanding care as a virtue of compassion in medicine, combined with the ideal of a separate and detached self, may create an ambivalence toward care and serve as a possible obstacle to caring. Caring is impaired by the underlying demand of staying detached and separate from the patient, constituting what I denote as a “gentleman’s” kind of care. That is, when the relational “in between” is not in focus, the ability to reach out toward the patient may be reduced or lost. Likewise, both the pervading attitude of “weg damit” in medicine, as well as its recording gaze, may contribute to inhibiting care and caring activities. So we have a situation in medicine and medical ethics where underlying structures related to the understanding of care as an attribute of the

emotionally detached and separate moral agent may contribute to impairing the actual exercise of care.

As a remedy, I suggest that medicine and medical ethics may profit from incorporating the theoretical insights from an ethics of care to a greater extent than is the case today. This involves both a relational understanding of care and a relational understanding of moral agency. Even though I do not fully engage with the question of whether care ethics should be associated with virtue ethics or not, I nevertheless point to the need for understanding care as something more than a character trait and a disposition to act. In doing so I make use of the situation in medicine and medical ethics with their emphasis on detachment and autonomy as an example for why care needs to be conceived of as something more than a virtue in order to obtain its purpose of “reaching out to something other than the self,” as well as leading to some type of action (Tronto, 1993, p. 102).

4.5 Final discussion

4.5.1 Just a question of etiquette?

Some scholars question the need of care in medicine in the first place, asking if patients might be satisfied with a physician who is simply well behaved (Kahn, 2008; Hem, 2009). Is it really necessary for physicians to care? Would it not be sufficient that physicians treat the patient with good manners? From his own experience of being hospitalized, psychiatrist Michael W. Kahn realizes that for him as a patient it did not matter so much whether the physician was caring as long as he operated in a professional and courteous way. This experience leads Kahn to believe that medical education and postgraduate training should place more emphasis on the etiquette-based aspects of medicine rather than attempting to foster care and compassion in clinicians (Kahn, 2008).

However, from my previous analysis of the ethical challenge of *harm in the absence of care* in the medical encounter, in meeting a patient with courtesy but without approaching the patient’s existential and emotional burden connected to the disease and to the state of being ill—to see the patient without *seeing*—the physician may add injury to the patient’s situation. Kari Milch Agledahl points to such a tendency in her empirical research, describing how patients’ personal worries were systematically ignored by the physicians, and how the physicians in the course of helping their patients through their biomedical

knowledge of anatomy and bodily processes actually ended up treating their patients as objects. Agledahl furthermore illustrates how the doctors, who often used an appropriate tone in the consultation, did not appear to *recognize* their concurrent moral offense. Based on her research, Agledahl suggests that moral infringements like these might be unavoidable in medical work, but that doctors, nonetheless, ought to be aware of the distress they cause and think about how they can reduce it (Agledahl, 2011).

I agree that such infringements might be difficult to eliminate completely in medical practice, and that being able to capture the patient's burdens or needs may be hard to attain during a single consultation. Nevertheless, it should be a central ambition for medical practitioners to *diminish* such infringements. In my view, the moral offenses that Agledahl here identifies breach the moral injunction of not turning away from someone in need. That is, by not recognizing or relating to the patient's existential burdens, the physicians inflict harm on the patient; they turn away from the patient's need. A possible solution to this ethical challenge in medicine will *not* be training in etiquette and good manners by way of checklists and simple rules for communication, but rather aiming for an increased understanding of the *ethical significance of the relational processes between physician and patient*, with a goal to expand the repertoire that physicians inherit for handling this kind of situation in medicine. It is essential that the ethical framework that physicians rely on in their medical work be analytically equipped to deal with questions related to the ethical challenges of preventing relational harm.

It is not that I envision a situation where physicians' work consists entirely of situations like these. As I have previously argued in connection with the critique of Kari Martinsen, most of the patients a physician deals with during the day require no more than "ordinary" medical care. However, some patients carry heavy burdens, and in order to avoid the infliction of harm on these patients, it is important, as I see it, that physicians be able to recognize the needs of these patients and to act accordingly.

Even though I do not agree with Kahn's conclusion, his article points to an important part of the task of exploring care in medicine, that of investigating the patients' experiences in relation to whether a physician is caring or not. This is an empirical research question in need of further research.

4.5.2 *The caring doctor—an oxymoron?*

Some opponents of care in medicine claim that caring interferes with the doctor's ability to process information in order to reach a decision. Caring inhibits the doctor from doing her real job, which, according to one author, is to reach a decision and act by initiating some kind of medical activity. It impairs the intellectual and impedes the most important part of being a doctor: "knowing what is wrong with patients" (Mackenzie, 1997, p. 687). As expressed by Graeme M. Mackenzie:

I have recently decided that being a doctor is a lot less about being caring and a lot more about the hard headed organisation of information with a view to making a decision. Overegging the caring pudding of general practice interferes with the process of decision making, with inherent dangers that the wrong decision is made or perhaps the more likely outcome that no decision is made. (Mackenzie, 1997, p. 687)

I think this author is wrong in two respects:

1. That caring inhibits or interferes with the organization of information and the process of decision making, and that caring and "knowing what is wrong with patients" are contradictory.
2. That the doctor's success is equivalent to reaching a decision and initiating action.

In this thesis I have aimed at illustrating what I have termed the epistemic potential of care: that the display of a perceiving eye contribute to enhancing the diagnostic process by facilitating the physician's ability to capture important diagnostic clues in the patient. The idea that caring interferes with proper medical treatment is a frequent objection (Curzer, 1993). In choosing between a caring doctor and a doctor saving your life, everyone chooses the lifesaver. But to put the problem in this way represents an oversimplification of the situation. As we have seen from my analysis, care is not equivalent to merely feeling sorry without initiating proper action. On the contrary, care is characterized as practical action and as work. A physician who holds your hand and soothes you instead of initiating the treatment necessary for your heart attack does not provide proper care. To be caring instead of initiating a proper medical treatment is not consistent with good caring, but is more like what Martinsen calls *sentimental care* (Martinsen, 2003a, 2003b).

My second objection to Dr. Mackenzie relates to his assumption that the doctor's main task is to know what is wrong with the patient, to reach a decision, and to initiate action. Seen in the light of what I have previously written about the "weg damit" attitude in medicine and its imperative of action, Mackenzie also seems to be subject to these imperatives. Further, just striving for an ideal of making diagnoses and decisions may generate disappointments and disillusion among physicians, as well as among the patients. Often the doctor does not know what is wrong, and the most appropriate thing to do may be to wait and see. Such an approach in this situation may express the attitude of reserve and receptivity that Martinsen advocates, and contribute to improving our sensitivity toward the patient. Sometimes a consultation may profit from a more reserved attitude on the part of the doctor, withholding interventions of medicine, referrals to specialists, offers of sick leave. We are trained to act and to initiate some kind of intervention, but in some situations that may instead just add insult to injury. Hence, to initiate action may not always be the best way to help the patient. As I see it, the "weg damit" attitude of medicine has gone too far when we chase the disease, while we at the same time risk "conquering" the patient at the expense of caring for him or her.

A possible objection to my work in this thesis raises the question of whether my reliance on care and the pathosophic lessons of von Weizsäcker actually implies a regression. Do I by this inquiry glorify the state of being ill, and underestimate the importance of recovery? Is not the success story of modern medicine connected to its potential for making people healthy, and do we not risk minimizing the successes of medicine by emphasizing reticence rather than active doing? Do we really want physicians to be passive, simply receptive to the patient's suffering instead of acting to suppress it? The development of antibiotics, insulin, anesthesia, and surgery represents, of course, a huge advance for our society, and returning to old medicine is not a realistic option. However, we should also be able to hold two thoughts at the same time, acknowledging the advances of modern medicine while simultaneously critically assessing some of the drawbacks of this development.

During the course of this thesis I have dealt with different pairs of concepts that reflect a tension in the field: the attitude of reserve ("ja, aber nicht so") versus the attitude of action ("weg damit"); caring versus curing; perceiving versus recording; interfering versus abandonment. These paired oppositions cover the span in the field of medicine, including its different practices and actors. They also reflect the dualities and ambivalences within which

medical practitioners navigate: between the biomedical demands and the humanistic ideals of medicine; between being professional and being personal; between a disease perspective that requires a recording eye to get an overview of the patient's disease and an illness perspective that requires a perceiving eye and an attitude of reserve to be able to see the patient's need and thus be able to care for him or her.

As I see it, an ethics of care provides a potential for dealing with some of this ambivalence. For instance, as we have seen from our discussion of the epistemological aspects of care, the situation in clinical medicine is not so clear cut that clinical diagnostics require only a recording eye. On the contrary, approaching patients with a perceiving eye, a relational awareness, and an openness toward the patient's as well as one's own emotional responses also may contribute to furthering the clinical proficiency of the medical practitioner. This is interesting, since it illustrates how the care perspective here crosses the traditional divide between curing and caring, pointing to how care as a way of seeing and comprehending the patient also contributes to the curing of the patient by refining and facilitating the diagnostic process. Whether we find ourselves in the role of physician, nurse, supervisor, moral philosopher, colleague, friend, or mother, by focusing on interpersonal relations and relational care and not on the practices related to the specific roles we inhabit, an ethics of care also manages to break with the traditional distinction between the personal and the professional, between the private and the public (Pettersen, 2006, 2008). Care may be relevant in relational processes at any level, between people on the macro level as well as on the micro level.

In my view, relating this capacity of care to the field of medicine and medical ethics may lead to a different dynamic in both the doctor-patient interaction and the interactions among the different health care professions. The traditional view of care in medicine as a virtue of a detached (male) physician is thus challenged by a relational understanding of care, and may also cut through the divide between the professions of nurses and physicians, as well as that between female and male. That is, by its capacity for breaking through the traditional dichotomies of moral theory such as the personal and the professional or the private and the public, an ethics of care may eventually be able to reconcile and combine the different dimensions of medical practice that I have been pointing to here—that is, caring versus curing, perceiving versus recording, a pat on the patient's back (“ja, aber nict so”) versus

curative action (“weg damit”)—thus possibly becoming an ethics both of caring and curing (Paulsen, 2011).

So, what about that oxymoron, then? As I have tried to argue, there is no contradiction here. Caring does not impair the important and most intellectual parts of being a doctor: knowing what is wrong with patients, organizing care at a practice level, and remaining enthusiastic. On the contrary, care may sharpen our diagnostic skill, as its situational grounding in practice secures a concrete and practical starting point for action. And, as current research reports indicate, being connected and involved with patients as health care personnel protects rather than exposes one to the risks of burnout and apathy (Deckard, Meterko, & Field, 1994; Halpern, 2001; Kearney et al., 2009).

Before concluding this thesis I wish to reflect some more about the didactical challenges of the introduction of care in medicine, and to indicate as well some relevant areas for further research emanating from this work.

4.5.3 Didactical challenges: Allowing for emotions and providing conceptual support

At the ends of both paper 1 and paper 2, I address the question of the didactical challenges related to the task of encouraging care in medicine, asking how we may train and educate physicians in seeing with a perceiving eye (Martinsen, E. H., 2011a) and how we may facilitate an understanding of the related self and of relational care in medicine (Martinsen, E. H., 2011b).

On the question of how to facilitate a perceiving eye in medicine, Martinsen does not offer any recipe. She does point out how the process of recording may impair our “seeing emotions.” In order to advance a perceiving eye in medicine, contributing to promote an openness toward the patient’s situation that reaches beyond the disease perspective captured by the recording eye, I think we need to encourage an openness toward the physician’s own emotions in meeting with patients. Instead of pushing away or “burying” our emotional responses in particular situations, we should deem these reactions valuable for the development and cultivation of an emotional awareness in the physician.

For a medical teacher it may be pivotal to provide an atmosphere during teaching, first and foremost at the bedside, where the students are encouraged to reflect on their own emotions in relation to their encounters with patients. To actively counteract an educational process

that inculcates detachment, it is important to allow for emotional responses from the students during the variety of different situations and scenarios they encounter. Training in mindfulness meditation has been suggested as one possible way of working with emotions in medical education, helping students become familiar with emotions, both their own and those of their patients (Shapiro, 2011). Narrative medicine and the use of specific techniques like reflective writing may also encourage attention to the emotional dimension of the experience of both patient and physician (Charon, 2006; Wald & Reis, 2010; Shapiro, 2011). Taking advantage of seminal events for creating an opportunity for reflection, making use of active learning methods that engage students in doing and discussing, and the use of effective role modeling represent some concrete and pragmatic teaching methods to deal with emotions in medical work, thus overcoming barriers to teaching “humanistic care” in clinical settings (Branch et al., 2001).

A systematic assessment and evaluation of the efficacy of these different approaches in medical education remains to be carried out, though, and this constitutes an area for further research. To what extent do these approaches actually lead to a greater awareness of emotions among medical students?⁴⁹ In what way, and to what extent, does a greater awareness of emotions influence their later interaction with patients? What is the pragmatic effect of this way of seeing and relating to patients in medicine?

I have been emphasizing the importance of physicians allowing for an openness to their own emotions in meeting with patients. However, it is important at the same time to point out that this does not imply that emotions are always to be given priority over rationality or that patients should be overwhelmed with the physician’s own emotionality. A disclosure of emotions can also be inappropriate on the part of a physician. That is, when the physician’s emotions are exposed primarily in the service of the physician himself, it can represent a violation of appropriate boundaries, and can give the patient a feeling of not being taken care of. Here we should draw a distinction between what may be called self-disclosure through empathetic validation and self-protective self-disclosure (Malterud & Hollnagel, 2007). Where the former may contribute to building a stronger doctor-patient relationship,

⁴⁹ At the Norwegian Knowledge Center for the Health Services there is an ongoing randomized study that examines whether a group-based mindfulness program can reduce stress and promote the personal development of medicine and psychology students. Among the primary outcome variables are empathy and mindfulness, and two of the hypotheses to be tested in the study are that the program of Mindfulness-Based Stress Reduction increases students’ empathy and increases their mindfulness (de Vibe, 2009).

the latter may lead to the opposite. That is, self-disclosure as a way for the physician to deal with his own emotions may be both sentimental and “self-protective.” Kirsti Malterud and colleagues show that when a physician reveals his own feelings and experiences in an encounter with a patient, this could be appreciated by the patients and thus positively influence the doctor-patient relationship (Malterud & Hollnagel, 2005; Malterud, Fredriksen, & Gjerde, 2009). However, these studies also raise important questions with regard to when and the conditions under which emotional disclosures would be professionally useful and responsible.

Even though we may have good intentions about implementing a care-oriented perspective in medical education, there are various barriers that may inhibit such an approach. So it is important to identify the informal and hidden curricula ubiquitous in hospitals and medical schools (Branch et al., 2001). The cultural mores exhibited by students, residents, teachers, and administrators at an institution transmit strong messages easily learned and internalized by novices. These messages may have more educational impact than the explicit lessons taught by the faculty in the formal curriculum.

As I see it, the ideals of detachment and non-interference, in combination with the cultivation of a recording eye and an underlying “weg damit” attitude to disease, represent underlying attitudes in medicine that impair a learning climate that could foster care in medical education. For this reason, medicine is in need of an ethical framework that also provides “conceptual support” for caring in medicine. This plea for conceptual support also relates to our understanding of an illness perspective in medicine. Although it may be much to demand of medical students that they be familiar, for instance, with the field of the phenomenology of illness, I think it would be essential for students to know at least some parts of these different approaches to illness and ill-being. It is mandatory, as I see it, that physicians be familiar with these additional ways of understanding illness in medicine, and that they also take part in the development of this kind of theory, not leaving it only to philosophers.

In addition to teaching such alternate perspectives in medicine, we may consider additional pedagogical “modalities,” such as the reading of fiction dealing with human ailment (Bondevik & Stene-Johansen, 2011) or the reading of pathographies, personal accounts of illness experiences (Hawkins, 1999). Another approach may be to make use of movies that deal with experiences of illness, like the movie *Wit* to which I previously referred (Colt,

Quadrelli, & Lester, 2011; Darbyshire & Baker, 2012). These ways of fleshing out a “bio(po)ethics,”⁵⁰ using different kinds of “poetic forms of storytelling” through novels, pathographies, or movies to teach about ill-being, thus represent an important field for further inquiry.

4.5.4 Further research

I believe the research to this point has shed light on theoretical traditions that are seldom touched upon in medical ethics and has raised new questions of both a theoretical and an empirical kind.

First, an interesting area for research emanating from this thesis is the further elaboration and discussion of the illness perspective of von Weizsäcker and its relation to similar perspectives within the field of the phenomenology of illness.

Further, in order to develop and refine a care perspective in medicine there are several areas in need of more investigation. For instance, how do the prominent empathy discourse in medicine and the conceptualization of medicine as an art relate to the implementation of care ethics into medicine? While nursing has focused on the concept of care, medicine has kept its focus on empathy. The care perspective represents another way of conceiving of the challenges in the interaction between physician and patient. To explore the intersection between these two different fields of inquiry in the context of medicine may add interesting and important knowledge to the understanding of the doctor-patient relationship, as well as contributing to improve our understanding of caring in medicine. The characterization of medicine as an art is often referred to as medicine’s “humanistic alibi,” but it is seldom precisely defined or circumscribed. Terms such as “clinical judgment,” “empathy,” “compassion,” “trust,” “comfort,” “intuition,” “humor,” “physical touch,” and “body language” are often invoked in attempts to define it (Stolt, 1998). Further analyzing the intersection between a care perspective and the notion of medicine as an art represents an interesting area for further research. How does care ethics relate to the understanding of medicine as an art? What may a care perspective add to this perspective?

⁵⁰ This term I borrow from the research proposal “Bio(po)ethics: From the ancient Greek theater to the festival of Cannes” by Jan Helge Solbakk (2012).

I have also pointed to the importance of investigating the patients' experiences in relation to whether or not a physician is caring. How do the patients conceive of a caring physician? What aspects of the physician's behavior do they emphasize? It may also be interesting to ask the same question of the physician: How does the physician experience her work when she emphasizes elements of care and emotional attentiveness in the clinical encounter, compared to situations when she does not focus on these aspects? And were there any differences in patient outcome that can be traced to whether or not the physician was caring?

5. Conclusion

The point of departure for this thesis has been my desire to expand the scope for physicians' interaction with their patients to include more than a biomedical approach subject to the sole imperative of curing. In contemporary medicine, biomedical demands and the disease dimension of human ailments focusing on curing have been dominant. In this thesis I try to develop a theoretical space for other dimensions of medicine focusing on *ill-being* and *care*.

I have taken as my point of departure von Weizsäcker's understanding of the pathic: ill-being conceived of as pathic being and expressed through the pathic modals of will, may, shall, can, and must. Being curious about the patient's ill-being as a medical helper may expand the physician's understanding of the patient, improving the physician's ability to capture the patient's need. However, to capture the "metaphysics" of being ill requires more of us than a theory-based reflection on ill-being. In the words of von Weizsäcker, we must also be able to see, or *hear*, the patient's need. By pointing to the importance of hearing the patient's "plea for help," von Weizsäcker put into words an important insight: that an illness perspective that aims to embrace the metaphysics of the ill also requires a perceiving eye. This way of seeing patients in medicine is important for capturing the patient's ill-being, and is an important prerequisite for care.

Care ethics challenges medicine's "eye" and can help us to see in ways other than the recording eye that is trained to look for relevant findings and to listen for relevant information as part of a targeted anamnesis. To see with what Kari Martinsen calls a

perceiving eye is to see unreservedly and receptively, thus allowing for sensation and emotions to work together. The perceiving eye opens for “a seeing emotion” that can help us to take better care of the patient as well as improving our clinical “nose” and ability to diagnose. I refer to the last-mentioned aspect as the epistemic potential of care.

Further, the understanding of the self in an ethics of care as essentially relational represents an important supplement to the understanding of the self as independent and separate from others. In this thesis I argue that medicine and medical ethics operate with an understanding of the moral agent as separate and disconnected and that such an underlying understanding of the self can promote distance rather than contact in the clinical encounter, thus preventing the development of a caring relationship. Situations in which harm is caused by a lack of care in the relationship, a harm captured in the prohibition against turning away from someone in need, represents the main ethical concern of an ethics of care, a concern that is rarely addressed in today’s medical ethics. Neither the principle of beneficence nor virtue ethics, with its focus on the individual character of the medical helper, are able to capture this kind of relational awareness in medicine. For this reason I argue in favor of a more thorough incorporation of an ethics of care in medical ethics, focusing on relatedness rather than separation, and promoting the development of a perceiving eye aimed at facilitating an emotional awareness among physicians.

By combining these insights of caring in medicine with a perspective on ill-being as conceived within the pathic modes of will, shall, can, must, and may, we may acquire a more nuanced arena within which to act to help patients in situations where both care and more strictly medical interventions can work in mutual collaboration. When illness is not only considered as something to get rid of (“weg damit”) but as something basic and constitutive of our existence—for our way of being human—the illness dimension of human ailment, as well as caring approaches, may be given more room to develop in medicine.

6. References

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Papers

Paper 1

Martinsen, E. H. (2011). Care for nurses only? Medicine and the perceiving eye. *Health Care Analysis*, 19, 15–27.

Care for Nurses Only? Medicine and the Perceiving Eye

Elin Håkonsen Martinsen

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Abstract In this paper I introduce a theoretical framework on care developed by the Norwegian nurse and philosopher Kari Martinsen, and I argue that this approach has relevance not only within nursing, but also within clinical medicine. I try to substantiate this claim by analysing some of the key concepts in this approach, and I illustrate the potential clinical relevance of this approach by applying it in relation to two care scenarios. Finally, I discuss some of the concerns that have been raised in relation to the aim of highlighting care in medicine.

Keywords Care · Doctor–patient relationship · Ethics of care · Kari Martinsen · Medical ethics · Nursing ethics

Introduction

Most of us agree that the assumption that “nurses care” and “doctors cure” is too simplistic, and that it is not uncommon for many nurses not to care very much at all, and for some doctors to care a great deal. However, in spite of this, there still is a theoretical discrepancy between nursing and medicine in relation to how care is handled; while care may be said to constitute an important part of professional self-understanding in nursing¹ [7, 27, 28, 38, 39], it still may be said to be situated in the margins of the ethical thinking in medicine [9, 42, 51, 52], and seldom applied to

¹ However, this does not mean that there is agreement on how care is to be understood in relation to nursing. On the contrary, the concept of care in nursing may be understood in different ways and relates to different theoretical traditions.

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medical education [8]. Nursing and the nursing profession may be criticized for monopolizing the concept of care [49].

In light of this theoretical discrepancy and the fact that many patients complain about a lack of care when meeting with their doctors, and experiencing ignorance, insensitivity or degrading behaviour [24, 26, 35], this urges a further analysis of the relevance of the care discourse in medicine. Implementing nursing care perspectives in medicine is controversial for a number of reasons, and may be why it has not been explored thoroughly. However, this is not a reason to avoid the topic. On the contrary, there may be powerful perspectives that have not been considered because of prejudice.

Therefore, in this paper I attempt to bring some of this knowledge from nursing into the field of medicine, taking the influential scholarly works on care by Norwegian nursing scientist and philosopher Kari Martinsen as my point of departure.² Kari Martinsen's work has influenced the current understanding of care in nursing in Scandinavian countries, and she belongs to a different theoretical tradition than the Gilligan's Anglo-American. Investigating Martinsen in the context of medicine will be interesting because it will represent an attempt to bridge the gap between related research traditions in medicine and nursing, and it will represent an attempt to relate the Scandinavian nursing debate on care inspired by phenomenology to the Anglo-American tradition of care ethics.

Interestingly, Søren Holm asks a similar question in his article, "What should other healthcare professions learn from nursing ethics?" [21]. However, Holm and I reach different conclusions: while Holm rejects the influence and importance of ethics of care in relation to nursing ethics and health care ethics in general,³ I welcome these perspectives, also in medicine.

In this paper I focus my attention on Martinsen's analysis of the different clinical gazes [41], and I will explore how this perspective may represent a prolific approach towards care in medicine. Care, by definition, "requires the recognition of a need" [57], so focusing on the way physicians *see* may represent an advantageous way of approaching care in medicine. The dominating gaze in medicine, however, is often referred to as powerful, objectifying and dehumanizing [14, 22, 24]. Therefore, I argue with Kari Martinsen that medicine needs to encourage and develop a "perceiving eye" [41]. The fostering of such an eye, or gaze,⁴ may facilitate care in each medical encounter, as well as refining clinical proficiency. In support of this claim, I first draw on some of the main features in Martinsen's care theory, trying to make her thinking comprehensible for readers outside Nordic countries as well. Subsequently, I analyse Martinsen's essay *Seeing with the Heart's Eye*, focusing on

² Even though Kari Martinsen's point of departure is the philosophy of nursing, her analysis focuses more on the relationship between the patient and health care professional in general than on the particular relationship between patient and nurse. Therefore I find her analyses also relevant in relation to medicine.

³ Holm concludes that other healthcare ethics should learn from the resistance of nursing ethics to analytic reductionism, however, he does *not* ascribe this resistance to influences from an ethics of care [21]. Instead, he points to other theoretical positions such as some feminist ethicists (however, *not* the feminist ethicists dealing with care) and modern particularists emphasizing the situational importance of ethical decision making, as well as influences from various schools of continental philosophy.

⁴ I use the terms 'eye' and 'gaze' interchangeably throughout in the text.

her analysis of what seeing means in health care (*ibid.*). By using examples, I aim to illustrate how the development of a sensuous and perceiving eye in medicine may be of ethical as well as epistemological importance for the clinical encounter. Finally, I will discuss different objections to focusing on care in medicine, in relation to the perspective developed above.

Kari Martinsen's Philosophy of Caring

Influenced by phenomenology and the historic roots of caring in nursing, Kari Martinsen has approached the concept of care through different levels of analysis. I rely for the most part in this paper on her later works in which she “is thinking with,” to use her own expression, the Danish philosopher and theologian Knud E. Løgstrup by analysing care phenomenologically [39–41].

Martinsen emphasizes care as being basic to human existence. She argues that as human beings we are basically social and dependent on other people and relies here on Løgstrup's view of human life as a life in interdependence⁵ [39, 40]. The assumption that human beings are interconnected and dependent upon each other thus represents a central ontological feature of Martinsen's theory. Thus, care constitutes a fundamental precondition of our lives: As human beings, we are basically dependent, and this dependency requires a human response in the form of care.

Martinsen always interprets a situation of care as being contextual, emotionally laden and particularistic in nature: “Care is to be concrete and present in a relationship by our senses and our bodies. It is always to be in a movement away from ourselves and towards the other,” she writes [36, p. 11]. Care is to relate to the other in an unconditional and spontaneous way as a response to the concrete situation of the other. Nevertheless, in order to accomplish this, we must be able to recognize his or her needs in the first place. Therefore, noticing the need to care may be conceived of as a basic element of care [57].⁶ Similarly, Martinsen argues that in order to care for the patient, “we must both be able to see and express the [patient's] appeal for help in order to strengthen the [patient's] life courage in the suffering” [37, p. 9]. She thus highlights the importance of noticing the need to care (to see), at the same time as focusing on the importance of practical action in care (to express). She also indicates an important ethical implication: namely, the strengthening of a patient's life courage. Consequently, care is not only about being empathic or being emotionally attached. The essential element, however, is to be able to recognize the need of the other and to act accordingly. For that reason, practical action represents an important dimension in Martinsen's care approach, together with a relational and

⁵ Through phenomenological investigations, Løgstrup came up with some basic phenomena which govern human interaction, and in his later writings he calls these modes of reaction “spontaneous manifestations of life” or “spontaneous utterances of life.” Løgstrup argues that phenomena such as trust, hope, compassion and the openness of speech are pre-cultural characteristics of our existence, and ontologically express the basic entanglement of individual human beings [29, 30].

⁶ According to Tronto, the three other elements of care are: to take care of, care-giving and care-receiving [57].

a moral dimension. Care is thus a trinity: “relational, practical and moral simultaneously” [3, 38].

Perceiving and Recording

A central feature of the care philosophy of Martinsen is her emphasis on perception in our interaction with others, as well as in clinical situations, and she considers perception to constitute an important part of clinical judgment.⁷ In the essay *Seeing with the Heart's Eye* Martinsen explores different dimensions of the clinician's gaze [41]. She starts by drawing a distinction between “perceiving” and “recording”: “By recording is meant the putting of oneself in an outside position, classifying,” she argues (p. 72). When we record, we systematize and differentiate, albeit within the frameworks of an already existing conceptual system. The recording eye is reductionistic and neutral; it may reduce living characteristics, such as a laughing face, to clinical signs, characteristics and marks. It is the eye of the disinterested observer, in which the other, as a person, may become indifferent to us. In her description of the recording eye, Martinsen is also inspired by and refers to Løgstrup's conception of the “eye of the epoch” [31] and to Michel Foucault's well-known analyses of “the classifying gaze” and “the examining gaze” in medicine [14].

In contrast the perceiving eye is characterized by openness towards the world, where sensation and emotions are working together, says Martinsen. The perceiving eye opens for “a seeing emotion,” in which we are touched and emotionally involved before we understand the needs of the other. Martinsen refers in this connection to the story of the Good Samaritan: The Samaritan saw the half-dead stranger and “was moved with compassion” [55]. He did not record first; instead, he was struck, pained by the wounded stranger. Martinsen refers here to the Greek word in the text, *esplanknistae*, which is “a verb made from a noun, meaning something to do with guts, stomach, abdomen, in other words an incredible physical pain” (Johannes Møllehave, cited in [41]). He was “pained in the gut,” meaning that “he saw with his whole body, which was touched” (p. 84). The Samaritan's understanding of the situation was thus led by his senses, by his sensuous and perceiving eye.

So, why does Martinsen bring the story of the Good Samaritan into an essay on seeing in health care?⁸ The story illustrates how the perceiving eye may facilitate care. In the story, the priest, the Levite and the Samaritan all saw the half-dead man, although they saw him in different ways. Significantly, the way they saw him had a major impact on the way they acted: the well-established and theoretically educated men, the priest and the Levite, saw the half-dead man and passed him by. Did they

⁷ Here Martinsen is influenced by Løgstrup and his position of “phenomenology of creation.” To be perceptive and open reflects thus the attitude of the phenomenology of creation, of being reticent and of receiving the other as a gift [39, 40].

⁸ The story of the Good Samaritan is regarded as an exemplary story in the Nordic tradition within care ethics and nursing ethics, and its intrinsic value of charity is also considered as part of the basic values in the Norwegian health care system [54, 48].

not trust their eyes? Did they have recording eyes and not perceiving eyes? Was the ailing man recorded as a stranger and therefore not of their concern, based on theory and culture? The Samaritan, on the other hand, got within the “perceiving range of life” [41]. He did not record first; instead, he was struck, pained by the wounded stranger.

What Gaze is at Work in Medicine?

How can we further transfer these theoretical insights to medicine? What gaze is at work here? As physicians we are trained to create a thorough medical history and make a clinical examination in order to give a proper diagnosis. The process of interviewing and examining the patient operates within a fixed framework, and even though we are encouraged to ask open-ended questions, the medical interview follows a standard scheme, investigating the patient’s heredity, social history, education, employment history, drug history, tobacco and alcohol consumption, home circumstances, and the history of the present complaint(s). Likewise, the physical examination of the patient operates within the same framework, leading us towards a possible diagnosis of the patient. This perspective is evident if we go to a recently updated text book in clinical examination for medical students [13]: “The examination really begins from the moments you set eyes on the patient,” Epstein et al. write (p. 20). “As the patient approaches you in the consulting or examination room, observe the posture, gait and character of the stride,” and when making your initial acquaintance with the patient, “the grip of the handshake usually provides some useful information” (p. 20–21). Thus, the first step of the examination is the inspection, during which we initially try to create a general impression of the patient: does she look well, or not? Is there any striking physical abnormality? Then we inspect the patient more specifically in relation to our examination of the different body systems, looking for signs and stigmata before we continue with palpation and auscultation of the heart and lungs. The medical exploring gaze thus operates within a fixed framework by systematizing, differentiating and classifying the information from the patient within a fixed totality. At the same time, physicians aim at remaining “professional” in meetings with patients. We usually understand the word professional to mean “keeping sufficient distance, not being overly involved (restraining emotions) and being objective and a matter of fact in one’s speech” [41]. In light of this, I will argue that the dominant gaze of medical practice is a recording gaze, focusing too heavily on diagnoses and diseases alone and leaving out the sensitive openness to the patient’s particular situation.⁹ This is also underscored by recent empirical findings, pointing to how physicians actually “essentialise” the patients’ stories by breaking them down into concrete complaints and categorising the symptoms into medical sense [1], as well as studies pointing to

⁹ Even so, there are different attempts to include the patient’s perspective to a greater extent into medical practice. Patient-centred medicine represents one example of such an approach, in which the importance of pursuing both the patient’s and the physician’s agenda is emphasized [4, 44]. The works on clinical empathy in medicine by Halpern [15, 16] represents another example, as well as the works of the Nordic general practitioners Malterud and Hollnagel [33, 34].

how the professional gaze actually may lead to humiliation and shame on part of the patient [35]. A possible consequence of such a recording gaze in medicine may be that physicians do not always “trust their own eyes” when meeting with patients who suffer. Let me offer an example:

Do We Not Trust Our Eyes?

In an article in *the Journal of the Norwegian Medical Association*, Kristin Ribe, who has suffered for several years from self-injury and suicidal thoughts, describes her meeting with health personnel (first and foremost physicians) at the emergency ward, arriving with self-inflicted bleeding wounds again and again [53]. She describes anger or indifference by the doctors who meet her with expressions such as “Are you here again, pull yourself together!” or “Now you must stop being silly!” or “We can’t use all our time on you. Don’t you see how many people are in the waiting room?” “One doctor did not even say hello to me,” she writes. “He just equipped himself and talked over an hour with the nurse about his cottage, while I was only something lying there, a scrap, a nothing” (ibid.).

It is tempting and may be relevant to draw a parallel here between the doctors’ behaviour and that of the priest and the Levite in the story of the Good Samaritan. Like the priest and the Levite, these doctors might not believe their own eyes. A young woman arrives at the emergency unit with bleeding wounds, and they meet her with ignorance, blame or anger. Did they not believe their eyes? They probably saw her with a recording gaze, founded on their medical knowledge and the medical culture. Among many health professionals, there has been a widespread tendency to think and talk about self-injuring patients as manipulative [43]. Did the doctors record the patient as manipulative and therefore outside of their moral concern—just like the priest and the Levite, who recorded the injured man as a stranger and as someone they were not obliged to help, based on their culture and their laws?

The recording gaze is powerful in its objectification of the other. Through a recording eye, we may see a person as an object or a completed fact, and this may threaten the person’s integrity. Integrity means that which must not be hurt, damaged or altered, but which should be respected and protected [23], and for a person who is seen as an object, it may be both painful and damaging. The self-injuring girl precisely delineates the damaging effects of a recording eye when she says she felt like “a scrap, a nothing” when treated by the doctor who ignored her. Through this type of objectifying behaviour, the doctor threatened her integrity. As a consequence, we see how the recording activity of the professionally trained eye may be damaging to the patient. However, this kind of viewing of the patient is also necessary in order to understand the patient’s medical condition and to reach a diagnosis. Thus, in order to care for the patient in a broader sense than just making a diagnosis and initiating treatment, we must strive to integrate and combine the two modes of seeing the patient: to see with openness and ease, such as seeing with the perceiving eye, while also seeing in an academic, exploring and evaluating way.

Besides the protection of patient integrity, Martinsen points to another important ethical implication of displaying a perceiving gaze in medicine, namely, the

strengthening of patients' life courage. This aspect of the perceiving gaze is also illustrated in the article by Ribe, in which she describes physicians who actually saw her, receiving her appeal for help, rather than abandoning it. She describes the good in a physician who saw her scars and said: "I see you have had a difficult time," and she describes the positive potential in such a response from another person, as something that was "very good to feel" and to take with her when she returned outside again [53]. "I need the physician at the emergency ward, whose hands trembled while he was suturing," she writes. "For him I was not routine. My wound, my pain moved him. And that was very good to feel, to take with me outside" (ibid.).

The Epistemic Potential of Care

Care may also be epistemologically essential in the clinical encounter, and in the following example I try to illustrate how seeing patients with a perceiving eye also may contribute to refining the clinical abilities of the physician:

Earwax is the problem for the next patient on the list, and the doctor envisages a short consultation, hoping to catch up with some work that is behind. After examining the patient's ears, the physician confirms the diagnosis and orders the appropriate treatment. The consultation is over with in five minutes, and the patient is supposed to leave. The doctor knows the patient from previous consultations; he is a middle-aged man, well-ordered and with no medical history. Still, today the physician becomes aware that something is different. Maybe it is something in the way the patient walks, or talks that makes it difficult for the physician to end the consultation as planned. Maybe it is something in the patient's eyes that touches the physician, so that instead of turning to his computer, he asks the patient one more time how he is doing. "I do not sleep," the patient answers. "Well, for how long a time have you not been sleeping?" the physician asks. "Since I was twelve years old," answers the patient, who then he loses his well-ordered appearance and tells a history of many years of child abuse in his childhood home, terrorized by a violent father. The patient is upset and starts to cry, and the consultation turns into something quite different from the treatment of bilateral earwax.

As I see it, this example illustrates the epistemic potential in holding on to the concreteness in the situation by displaying the sensuous and perceiving eye instead of immediately starting a process of abstraction. The physician could have disciplined the situation by following his plan for an efficient consultation and doing a proper job treating the patient's earwax. And many physicians do end their consultations just like this. But an extra weight in the patient's steps or something in the patient's eyes moved the physician, and by being aware of his own "seeing emotions" in meeting with the patient, he captured some important information regarding the patient's clinical situation. This is important both in regard to the medical state of the patient, by initializing further examination and treatment of his insomnia, but also in relation to bringing forward the courage to live, as Martinsen expresses it.

To Care or Not to Care?

So far, I have discussed central conceptions in the care philosophy of Kari Martinsen in relation to medicine, focusing on her discussion of seeing in health care and her conceptions of the perceiving and the recording eye. I have asserted that seeing in medicine is dominated by a recording gaze and that the development of a sensuous and perceiving gaze is important in order to facilitate care and refine clinical proficiency.

There are many aspects to discuss here, and I will not discuss Martinsen's theoretical perspective in this context more,¹⁰ but I will discuss the possible drawbacks of highlighting such a perspective in medicine. In this connection, it is important to point out that even though care has been a marginalized area of inquiry within the philosophy of medicine and medical ethics, there is an ongoing transition in the medical ethical landscape by which the feasibility of ethics of care in relation to medicine is being recognized within philosophy of medicine [10, 11, 42, 58], medical education [8], feminist ethics [56] and medical anthropology [25].

There are, of course, many worries that might be raised for a care orientation in the context of medicine and medical ethics. In the following section I will deal with some of the arguments related to the assertion that a care perspective in medicine will likely bring about bad consequences for patients and physicians. By this, I limit my discussion to exclude critical arguments trying to assert that the notion of care itself is problematic and unnecessary [2, 12, 19]. Let us look at some of the objections that are particularly germane to the present discussion:

First, it might be said that caring interferes with proper medical practice by inhibiting the doctor's organization of information, in addition to the decision-making process [32]. Beauchamp and Childress, discussing the virtue of compassion in medicine, point to this connection in how compassion "can blind reason and impartial reflection" [5]. "Constant contact with suffering can overwhelm and even paralyze a compassionate physician and nurse," they write (p. 40). In response to this worry, it is important to point out that there is nothing intrinsic to the care perspective that excludes appropriately detached forms of concern and compassion, to paraphrase Carse [9]. "A good health care professional should be able to summon the appropriate degree of emotional detachment, or equanimity, when this is crucial to serving the well-being of the patient," Carse argues (p. 23).

If we relate this objection to Martinsen's perspective, we may ask whether the display of a perceiving gaze in medicine may inhibit rather than facilitate medical practice. First, according to Martinsen, proper care is not concordant with actions that disrupt the necessary medical work. Here, I rely on her emphasis on professional reflection in relation to the clinical encounter. In Martinsen's view, clinical judgment depends on professional knowledge to structure and organize the

¹⁰ Martinsen's perspective has been debated widely. She has been criticized for pursuing an altruistic notion of care [18, 50], and for emphasizing "samaritanism" as an ethical ideal in relation to the ethics of care [50], as well as for romanticizing nursing practice [17]. She has been criticized for toning down the importance of research and the need for scientific knowledge in nursing [46]. The use of Løgstrup's ethics and phenomenology as the main source for health care ethics also has been criticized [20]. A more substantial elaboration of this critique is found in my forthcoming PhD thesis.

information, as well as an ability to be open and sensitive toward the patient. Because of this, comforting the patient instead of initiating proper medical treatment is not consistent with good care, but is more like what Martinsen denotes as *sentimental care*. According to Martinsen, sentimental care is care in which the caregiver's participation in the other person's suffering is limited to the caregiver's self-centred emotions [38]. When the caregiver confines him or herself to pitying the patient and refrains from helping the patient in a professional manner, the care becomes sentimental. Second, as we experienced in the example with the patient with earwax and insomnia, care may be epistemologically essential in the clinical encounter because caring attitudes and sensitivities may allow access to important knowledge about the patient's subjective experiences of illness, which may be crucial in acquiring a proper understanding of the patient's condition.¹¹ Accordingly, from my point of view, the understanding of care as an inhibitor of medical practice may be due to an inadequate conception of care as well as a failure to recognize how care may contribute to refining clinical proficiency by being epistemologically relevant.

Second, it might be argued that caring for a patient may lead to difficulties for the physician with regard to causing the patient therapeutically necessary pain or breaking bad news to the patient [12]. As I see it, such a worry is based on an inadequate conception of care and I refer to Martinsen's conception of sentimental care; according to Martinsen, care is more than feeling sorry for, having a liking for, or being emotionally attached to someone. Care also involves a practical participation in the other person's suffering and concrete action based on professional judgement. Therefore, to leave out a painful but important procedure for the patient because of one's caring for that patient is not concordant with proper care.

Third, it might be said that there are important moral issues that may fall outside the reach of an ethics of care. One main worry is that an ethic of care will have nothing to say about certain forms of injustice [45]. Will physicians be inclined to favour their patients over other physicians' patients or the need of the community? In this regard it is important to point out that the partialistic feature of an ethic of care does not afflict the caring agent with "tunnel vision" [42]. This point is also evident in Martinsen's perspective that, besides emphasizing a spontaneous care response towards the other, mediated through a perceiving eye, also emphasizes the importance of professional judgment and reflection in the clinical encounter [39]. Accordingly, the professional may not have the opportunity to focus his or her attention on the care of one person or group of persons to the complete exclusion of the wants and needs of others. It is also important to point out that what is in question in the care perspective is not necessarily to question the importance of justice, but pointing to *additional* ways of moral reasoning [9]. Therefore, "an

¹¹ The epistemic potential of care also is underscored by the conception of *sensibility* as explicated by Nortvedt [47]. Nortvedt argues that sensibility, understood as the affective part of moral sensitivity, has significance for the health care workers' moral motivation and clinical understanding: "To be emotionally affected by the expressions of illness, of bodily weakness and pain, opens up for a medical gaze that both can capture clinical signs of pathology while at the same time being able to care for the human condition of the patient and sick individual," he argues (p. 218).

adequate moral theoretical approach may well involve an integration of the justice and care orientations so as to retain their respective strengths through rehabilitated notions of ‘justice’ and ‘care’” [9].

The fourth difficulty relates to the previous objection and concerns the possible tendency of an ethics of care to allow favouritism. “It would require a saint to care for some really disgusting patients,” says Curzer [12], referring to a claim that it is not possible to care equally for all patients. This is one of the reasons I consider Ribes’s article (2009) to be both interesting and relevant. There has been an understanding among doctors that self-injuring patients are difficult, demanding and manipulative [6, 43]. At the same time, recent research has found that good care from doctors and health personnel is important for these patients to recover [43]. So, how do we manage to care for “difficult” and “demanding” patients? I do not have a simple answer to this question. Yet, I consider Martinsen’s understanding of care as being able “to see and express the [patient’s] appeal for help,” involving an emotional awareness and a relational and a practical competence to represent a more feasible approach to the problem than an understanding of care, meaning to “have a liking for,” which involves emotional attachment. The latter refers to the understanding of care that Curzer refers and criticizes in his article [12]. Following Martinsen, the important task is not whether we like the patient or whether we feel attached to the patient as a friend, but whether we are able to see, or become aware of the person’s suffering and express it independent of his or her sympathetic or unsympathetic traits.

Burnout on the part of the physician also is identified as a possible drawback to caring in medicine. A usual way of approaching this issue in medicine has been to argue in favour of a detached model of care in which the physician remains professional, i.e., cool and undisturbed by the patient’s situation. On the contrary, the American physician and philosopher Jodi Halpern argues convincingly against such an ideal of detachment in medicine, pointing to empirical studies indicating an increased risk of burnout in relation to a medical practice characterized by detachment, as well as pointing out how an empathic communication with patients “makes being a physician more meaningful and satisfying” [15, 16]. Kari Martinsen also has been criticized in a similar manner for pursuing an altruistic concept of care, allowing for self-sacrifice on the part of the health care professional [18, 50]. I do not agree that Martinsen’s care perspective is altruistic in the sense that it implies self-sacrifice. As I see it, these critics make their claim without taking into consideration the consciousness of limit inherent in the professional reflection that Martinsen emphasizes in relation to practical care work.

Conclusion

In this paper I have argued that the development of a sensuous and perceiving gaze is important in medicine in order to facilitate care and refine clinical proficiency. Relying on the care philosophy of Kari Martinsen, I suggest that an understanding of care as being able “to see and express the [patient’s] appeal for help” may represent a fruitful way of dealing with care in medicine. By this, both the importance of

attentiveness as conceptualized by the perceiving eye, as well as the relational and practical dimension of care, are emphasized. Such an approach may further contribute to protecting the integrity of patients, in addition to contributing to refining the clinical abilities of physicians in the clinical encounter. Possible problems have been addressed, while some questions are also left open for further inquiry: For instance, how do we train and educate physicians in this way of seeing in medicine?

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Paper 2

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Paper 3

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